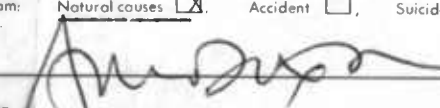
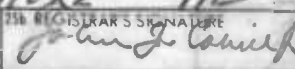


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 3 2 5 8	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWARD J. MACH										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 9 28 19 82	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 1 16 17 65	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 65	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 28 19 82		2d. HOUR 4:05 P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 626 S. Potomac St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13. STREET ADDRESS 626 S. POTOMAC ST.			
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH MACH				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOSEPHINE JAROSINSKI							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 21301 0333		17. INFORMANT ADDRESS AGNES MACH 626 S. POTOMAC ST.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u> 4029 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 9-29-82			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL BURIAL				23b. DATE 10-2-1982		23c. NAME OF CEMETERY OR CREMATORY SACRED HEART JESUS		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD			
24. FUNERAL DIRECTOR NAME RAYMOND L. KACZOROWSKI				ADDRESS 2525 FLEET ST.		25a. DATE OF DEATH SEP 30 1982		25b. REGISTRAR'S SIGNATURE 			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 2 5 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Catherine (nmi) MACHEN			2a. DATE OF DEATH MONTH DAY YEAR SEPT. 2, 1982			2b. HOUR 9 ⁰⁰ P ^M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5/4/1882		6. AGE (IN YEARS LAST BIRTHDAY) 100 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garden Village Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY -----		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1608 Joplin St. 21224	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown Guestfoot					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 215.01.3340D		17. INFORMANT ADDRESS Harrison J. Ward (Same as 13e)					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 1749 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Adenocarcinoma of the Breast</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months -	
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Generalized Atherosclerosis; Chronic Anemia; Recurrent Urinary Tract Infection</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the deceased) attended the deceased on <u>9/24/82</u> , to <u>3/19/71</u> , that (I) (we) last saw the deceased alive on <u>9/24/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <u>Albert B. Bradley</u>				DEGREE MD		22c. DATE SIGNED 9/3/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert B. Bradley, Md.				22e. ADDRESS 4900 Belair Rd Balt MD.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9/3/1982		23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Walter Brooks Bradley, Inc				ADDRESS Dundalk MD 21222		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 3 1982	



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1	2	3	4	5	6	7	8	9	10
11	12	13	14	15	16	17	18	19	20
21	22	23	24	25	26	27	28	29	30
31	32	33	34	35	36	37	38	39	40
41	42	43	44	45	46	47	48	49	50
51	52	53	54	55	56	57	58	59	60
61	62	63	64	65	66	67	68	69	70
71	72	73	74	75	76	77	78	79	80
81	82	83	84	85	86	87	88	89	90
91	92	93	94	95	96	97	98	99	100

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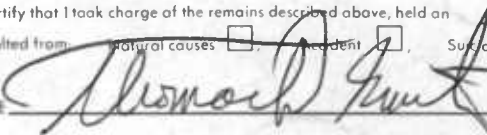

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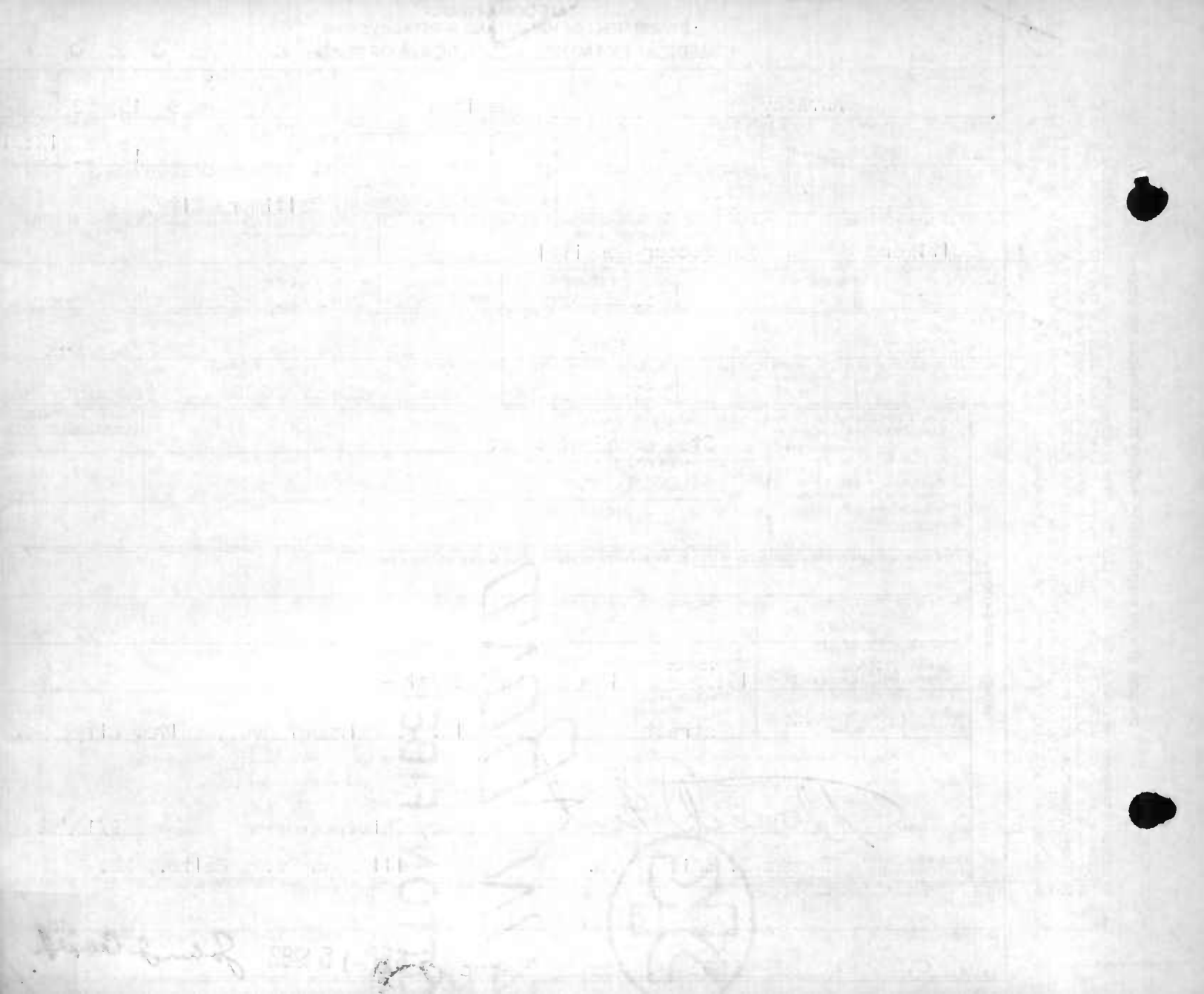
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 2 2 3 2 6 0	
1. DECEASED NAME (TYPE OR PRINT) Anthony Madison						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 13 1982		2b. HOUR M			
1. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 3 29 61	6. AGE (IN YEARS) LAST BIRTHDAY 21 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 13 1982		2d. HOUR 12:31 a M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secour Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2605 W. Fairmount Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST Milton E. Madison				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sylvia Seagwick							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 217-66-2829		17. INFORMANT ADDRESS Sylvia Madison 2605 W. Fairmount Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stab wound of chest DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR MONTH DAY YEAR 10:35 9 12 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject stabbed						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2500 Blk. W. Fairmont Ave., Balto. City, Md.						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 			TITLE (SPECIFY) M.D. Deputy Chief MEDICAL EXAMINER					DATE SIGNED 9/13/82			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.			ADDRESS 111 Penn St. Balto., MD.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9/17/82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Md				
24. FUNERAL DIRECTOR NAME Wm. C. Marhc F/H			ADDRESS 1101 E. North Avenue		25a. DATE REC'D. BY REGISTRAR SEP 15 1982		25b. REGISTRAR'S SIGNATURE 				



NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 3 2 6 1 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FLAKE LINNEY MAHAFFEY										2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 12, 1982				2b. HOUR M	
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR June 21, 1908			6. AGE (IN YEARS-LAST BIRTHDAY) 74 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.						
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 315 Woodbourne Ave.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary			12b. KIND OF BUSINESS OR INDUSTRY Waterproofing			
13a. STATE Maryland			13b. COUNTY			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 315 Woodbourne Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Edgar Mahaffey, Sr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Baxter Linney									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II			17. INFORMANT Florence E. Mahaffey			ADDRESS Same						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest 1459 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of the mouth DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Coronary heart disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 9/10/82 , 19 82 , to 9/12/82 , 19 82 , that (I) (we) last saw the deceased alive on 9/10/82 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE James H. Biddison, M.D.						DEGREE M.D.			22c. DATE SIGNED 9/13/82						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James H. Biddison, M.D.						22e. ADDRESS 6301 N. Charles St. Baltimore, Md. 21212									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Sept. 13, 1982			23c. NAME OF CEMETERY OR CREMATORY Greenmount			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland						
24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212						25a. DATE REC'D. BY REGISTRAR SEP 16 1982			25b. REGISTRAR'S SIGNATURE John S. Smith						



COLLON LABEL NO. 1330



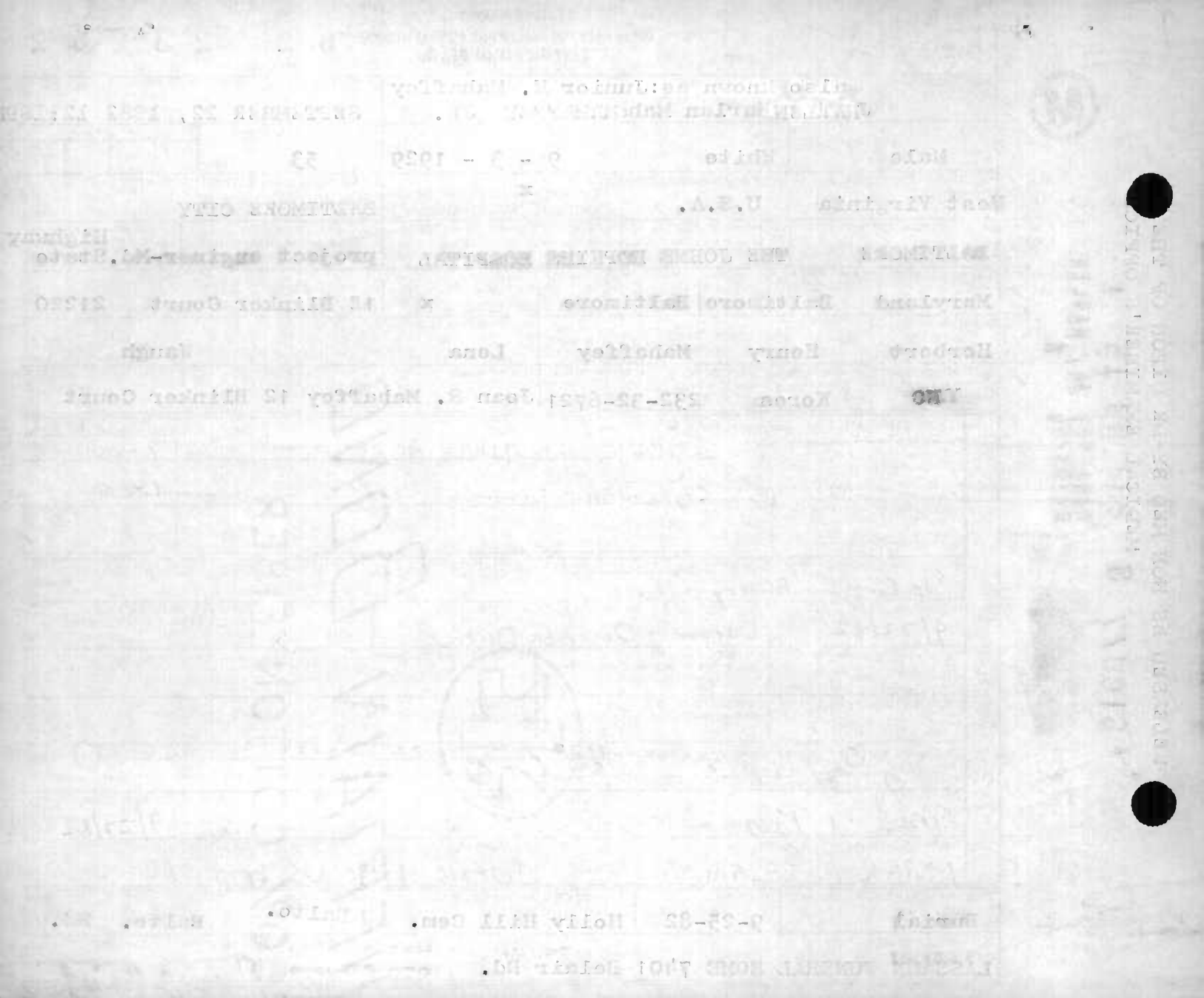
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 2 3 2 6 2

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Junior Harlan Mahaffey		SEPTEMBER 22, 1982		12:18P	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male	White	9 - 3 - 1929	53		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
West Virginia	U.S.A.		BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
BALTIMORE	THE JOHNS HOPKINS HOSPITAL		project engineer-Md. State Highway		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS	
Maryland	Baltimore	Baltimore		12 Blinker Court 21220	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Herbert Henry Mahaffey		Lena Henry Waugh			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
YES		Korea	Joan R. Mahaffey 12 Blinker Court		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 1 YEAR					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>1/2p Coronary Artery Bypass</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
9/22/82	Coronary Occlusive Disease				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>9/20</u> , 19 <u>82</u> , to <u>9/22</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>Sept. 22</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.					
22b. SIGNATURE <u>Mark A. Talamini MD</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>9/22/82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MARK A. TALAMINI</u>		22e. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial	9-25-82	Holly Hill Cem.	Balto. Balto. Md.		
24. FUNERAL DIRECTOR NAME ADDRESS			25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
LASSAHN FUNERAL HOME 7401 Belair Rd.			SEP 27 1982	<u>Joan R. Mahaffey</u>	



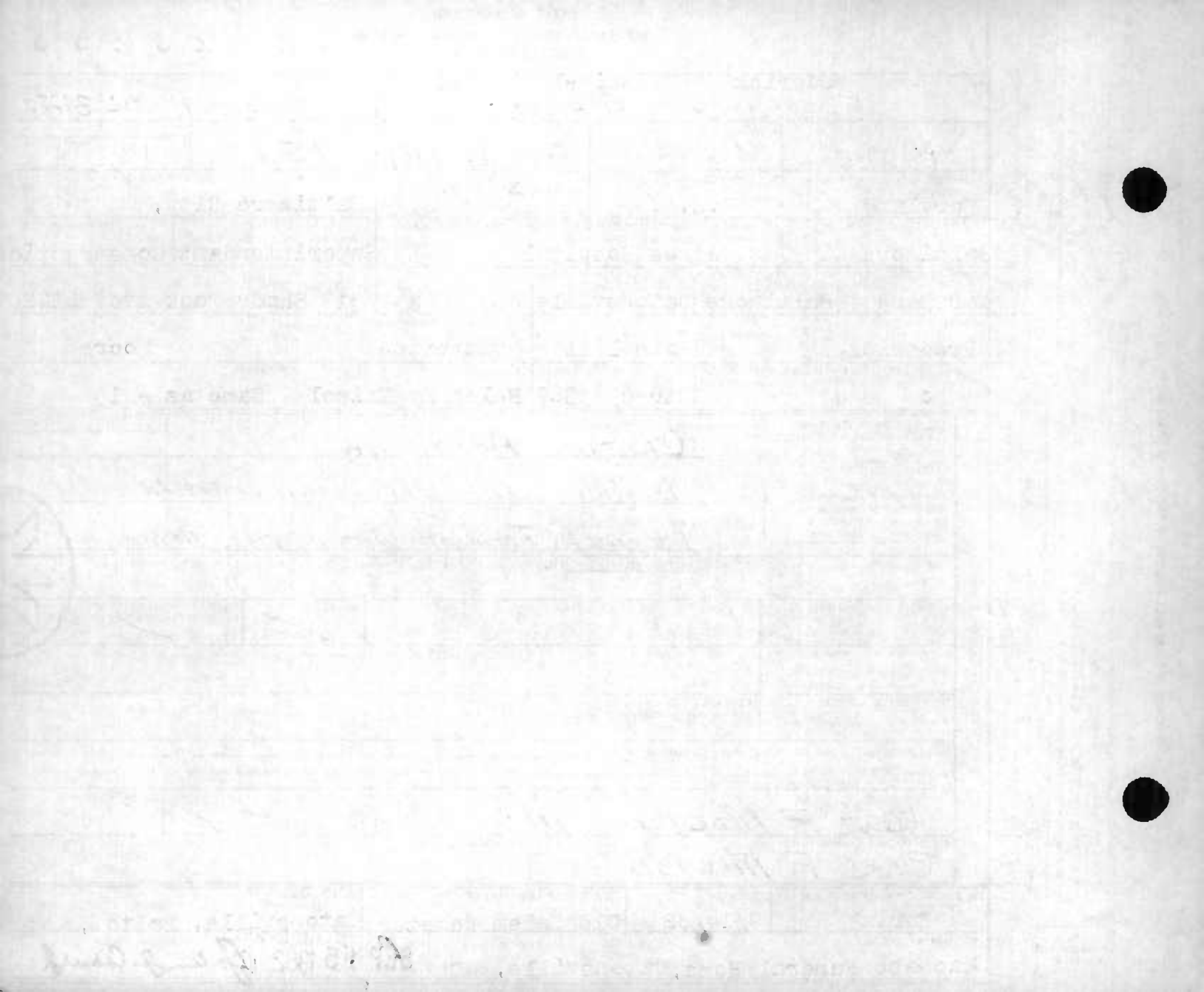
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					8 2 2 3 2 6 3 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Frederick Maisei III FREDERICK MAISEI					2a. DATE OF DEATH MONTH DAY YEAR SEPT 11 1982 3:28 PM					
3. SEX MALE		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR FEB 24 1907		6. AGE (IN YEARS (LAST BIRTHDAY)) 75 YRS		7b. HOUR 3:28 PM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.				
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Superintendent		12b. KIND OF BUSINESS OR INDUSTRY Construction		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Maisei II					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Moore					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 210-03-5387		17. INFORMANT ADDRESS Helen K. Maisel Same as # 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) MESENTERIC Thrombosis with intestinal hemorrhage									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE BERT F. MORTON					DEGREE M.D.			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERT F. MORTON					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/14/82		23c. NAME OF CEMETERY OR CREMATORY Old Salem Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Balto., MD		
24. FUNERAL DIRECTOR NAME MacNabb Funeral Home, Catonsville, MD					25a. DATE REC'D. BY REGISTRAR SEP 15 1982			25b. REGISTRAR'S SIGNATURE John J. Carver		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 2 3 2 6 4	
1. DECEASED NAME (TYPE OR PRINT) John == Malescio					2a. DATE OF DEATH MONTH 9 DAY 18 YEAR 82			2b. HOUR 10¹⁰ PM			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH 4 DAY 20 YEAR 1885		6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS		IF UNDER 1 YEAR MONTHS 9 DAYS 10			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baker		12b. KIND OF BUSINESS OR INDUSTRY Bakery			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 919 Quantril Way 21205		
14. FATHER'S NAME FIRST Frank MIDDLE F. LAST Malescio			15. MOTHER'S MAIDEN NAME FIRST Rose MIDDLE ? LAST ?								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW-1		17. INFORMANT John Malescio		ADDRESS (Prearranged)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Cardiorespiratory arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 min	
DUE TO, OR AS A CONSEQUENCE OF (b) atherosclerotic coronary vascular disease										50 yrs	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Probable aspiration pneumonia											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) this hospital attended the deceased from 12/2/76 , 19 76 to 9/18 , 19 82 , that (I) (we) last saw the deceased alive on 9/18 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE TV Parran Jr			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 9/18/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. V. PARRAN Jr MD			22e. ADDRESS Balt City Hosp Dept of Med								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/21/1982		23c. NAME OF CEMETERY OR CREMATORY Holly Hills Ceme.		23d. LOCATION CITY OR TOWN Middle River, Balto. COUNTY Md STATE				
24. FUNERAL DIRECTOR NAME Raymond C. Fink			ADDRESS Glen Burnie, Md.			25a. DATE REC'D. BY REGISTRAR SEP 20 1982		25b. REGISTRAR'S SIGNATURE John J. [Signature]			



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, page 3 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, any injury, or other traumatic event, the medical examiner must be notified of this.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 2 6 5
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN - MALINOWSKI			2a. DATE OF DEATH MONTH 9 DAY 1 YEAR 82		2b. HOUR 8⁴² P.M.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH 10 DAY 27 YEAR 08		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALT. CITY MD.	
10. CITY OR TOWN OF DEATH BALT. CITY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WYMAO PARK HEALTH SYSTEM INC		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY SEAMAN
13a. STATE MARYLAND		13b. COUNTY CAROLINE	13c. CITY OR TOWN GREENSBORO	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Box 412, Route #1
14. FATHER'S NAME FIRST LUKE MIDDLE ASA LAST MALINOWSKI			15. MOTHER'S MAIDEN NAME FIRST ANTANIA MIDDLE - LAST ZALEWSKI		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN		16b. SOCIAL SECURITY NO. 219-12-5584		17. INFORMANT ADDRESS Greensboro Rt.1, Box 412/ Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY 1519 IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 6 DAYS MONTHS
DUE TO, OR AS A CONSEQUENCE OF (b) ASPIRATION		
DUE TO, OR AS A CONSEQUENCE OF (c) UNRESEMBLABLE GASTRIC CARCINOMA		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **a**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED GASTRIC CARCINOMA	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (his hospital) attended the deceased from Sept 1 , 19 82 , to Sept 1 , 19 82 , that (1) (we) lost saw the deceased alive on Sept 1 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.			
22b. SIGNATURE CHARLES J. Yeo M.D.		DEGREE MD	22c. DATE SIGNED 9/1/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES JOHN YEO M.D.		22e. ADDRESS WYMAO PARK HEALTH SYSTEM INC.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Sept. 4, 1982	23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem.	23d. LOCATION CITY OR TOWN Baltimore, -- COUNTY Maryland STATE
24. FUNERAL DIRECTOR NAME Lilly & Zeller Inc. ADDRESS 1901 Eastern Ave.		25a. DATE REC'D. BY REGISTRAR SEP 3 1982	25b. REGISTRAR'S SIGNATURE John J. Conish

July 2 Keller Inc. 1901 Jackson Ave.
Sept. 11 1903 St. Stanislaus Cn. Baltimore, -- Maryland

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, it must be certified as such.

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 2 6 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LUCY BATEY MALONE			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 26, 1982		2b. HOUR 7:27AM		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 02 1898		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TENNESSEE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	
13a. STATE TENNESSEE		13b. COUNTY DAVIDSON		13c. CITY OR TOWN NASHVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM L. BATEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NETTIE SCALES		16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN TENNESSEE DAVIDSON NASHVILLE			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		17b. SOCIAL SECURITY NO. 413-76-9690		17c. INFORMANT HANK SPIKES			
18. FATHER'S NAME FIRST MIDDLE LAST WILLIAM L. BATEY		19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NETTIE SCALES		20. STREET ADDRESS APT. R 6 2011 RICHARD JONES ROAD 37215			
19a. DATE OF OPERATION φ		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED φ		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 9/21 , 19 82 , to July 26 , 19 82 , that (I) (we) last saw the deceased alive on July 26 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE Miguel A. Delgado		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22b. DATE SIGNED 9/26/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Delgado, MD Miguel		22e. ADDRESS John's Hopkins Hosp.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL/BURIAL		23b. DATE 09-29-82		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE NASHVILLE DAVIDSON TN.	
24. FUNERAL DIRECTOR NAME BALTO., MD.		24b. ADDRESS 21229		25a. DATE RECD. BY REGISTRAR SEP 29 1982		25b. REGISTRAR'S SIGNATURE John J. Conner	
24c. HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.							

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

4275

IMMEDIATE CAUSE (a)

Cardiac - Pulmonary arrest.

DUE TO, OR AS A CONSEQUENCE OF

(b)

Probable Septic shock

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

*Perineatal abscess; esophageal stricture*APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 2 2 3 2 6 7
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN THOMAS MANLEY		2a. DATE OF DEATH MONTH DAY YEAR 9 14 82		2b. HOUR 5:05 p.m.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12-25-24		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. City		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC BALTIMORE, MARYLAND 21218		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John T. Manley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Royston		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217 12 6624	
17. INFORMANT ADDRESS Mrs. Helen Elaine Manley -1233 Evesham Ave.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 cardiovascular arrest DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) squamous cell carcinoma of the lung PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from SEPTEMBER 12 1982, to SEPTEMBER 14 1982, that (we) last saw the deceased alive on SEPTEMBER 14 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (do not) view the body after death.		22b. SIGNATURE Paul Mullen MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Mullen MD		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-17-82	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.		24. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd.-21206		25a. DATE REC'D. BY REGISTRAR SEP 17 1982	
25b. REGISTRAR'S SIGNATURE John J. Conner							

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200
201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300
301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400
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501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600
601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700
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901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARRETTA EVELYN MANN					2a. DATE OF DEATH MONTH DAY YEAR 9/8/82		2b. HOUR 10:50 PM		
3. SEX FEMALE		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR 1/27/08		6. AGE IN YEARS (LAST BIRTHDAY) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY ---		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST ? ? ?		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ? ? ?		16. STREET ADDRESS 4401 GRANDVIEW AVE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT ADDRESS ATTORNEY					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4590 D.C., multi-system failure DUE TO, OR AS A CONSEQUENCE OF (b) sepsis DUE TO, OR AS A CONSEQUENCE OF (c) --- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days 10 days									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ADDN, Gargano's Block									
19a. DATE OF OPERATION 9/3/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED sepsis, old tuberculosis				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from 7/31/82 to 9/8/82 , that (I) (we) last saw the deceased alive on 9/8/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Steven Blaskell		DEGREE		22c. DATE SIGNED 9/8/82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven Blaskell			
22e. ADDRESS 201 E Union Pkwy Balt 21210		22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/11/82		23c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S		23d. LOCATION CITY OR TOWN COUNTY STATE ELLICOTT CITY MD			
24. FUNERAL DIRECTOR Charles E. Howard		ADDRESS 3617 Chestnut Ave		25a. DATE REC'D. BY REGISTRAR SEP 14 1982					

ANGELA EVELYN WELSH

15-108 11-108

BALTIMORE, CITY

UNION MEMORIAL HOSPITAL

BALTIMORE

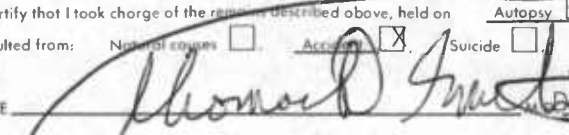
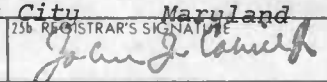
REPRODUCTION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 23269	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Patricia Marrichi Marycky						2a. DATE OF DEATH KNOWN ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 22 1982		2b. HOUR M 10:15			
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 23, 1952	6. AGE (IN YEARS LAST BIRTHDAY) 30 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 9 22 1982		2d. HOUR P M			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Westminister		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1876 Snydersburg, Rd 21157			
14. FATHER'S NAME FIRST MIDDLE LAST Charles O LaHatte				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Patricia A Chenowith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-50-5457		17. INFORMANT Mr James P Marrichi				ADDRESS Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cranio cerebral trauma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR 12:30 M. 9 17 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver in auto/fixed object collision							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Sullivan Rd. Westminister Carroll Md.							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <input type="checkbox"/> Accidents <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 		TITLE (SPECIFY) Deputy Chief						MEDICAL EXAMINER DATE SIGNED 9/23/82			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.		ADDRESS 111 Penn St. Balto., MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/27/82		23c. NAME OF CEMETERY OR CREMATORY Good Shepherd		23d. LOCATION CITY OR TOWN COUNTY STATE Ellicott City Maryland					
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland						25a. DATE REC'D. BY REGISTRAR SEP 24 1982		25b. REGISTRAR'S SIGNATURE 			

TO :

FROM :

[Handwritten Signature]

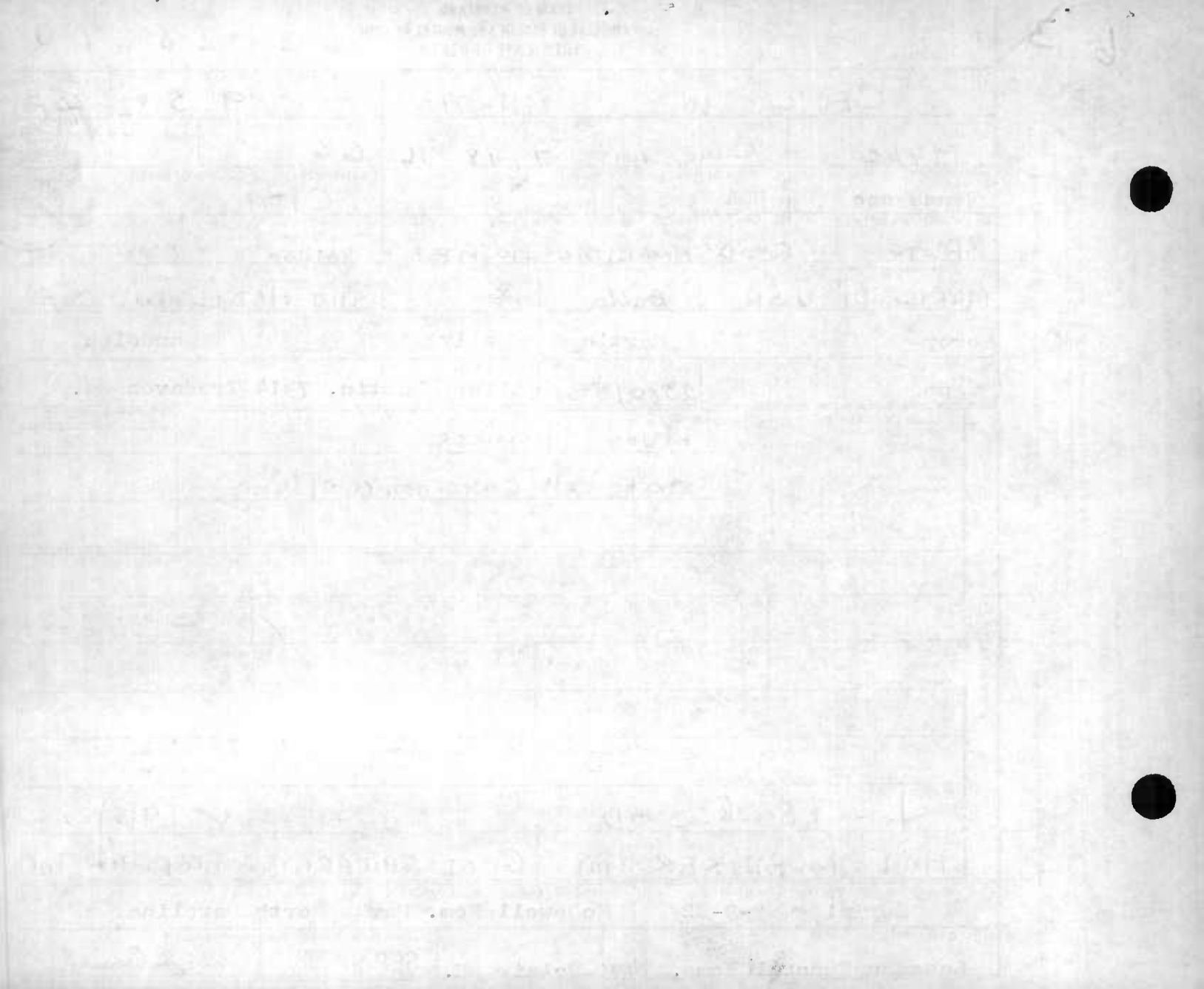
RECEIVED
FBI
JAN 10 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 only to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 2 2 3 2 7 0 REG. NO.							
1 DECEASED NAME (TYPE OR PRINT)		FIRST CECIL		MIDDLE W		LAST MARTIN		2a DATE OF DEATH MONTH DAY YEAR 9-5-82	
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 7 18 16		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		2b HOUR 4 P.M.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH CITY MD.			
10 CITY OR TOWN OF DEATH BALTO.		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder		12b KIND OF BUSINESS OR INDUSTRY Bethlehem Steel	
13a. STATE MARYLAND		13b. COUNTY BALTO.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5110 HAZELWOOD AVE	
14. FATHER'S NAME FIRST MIDDLE LAST Leroy Martin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sally Randolph							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b SOCIAL SECURITY NO. 23801531		17. INFORMANT ADDRESS Alford Martin, 7314 Tredavon Rd.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver failure. 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Oat cell carcinoma of lung. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: —									
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8-22-1982, to 9-5-1982, that (I) (we) last saw the deceased alive on 9-5-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Anil Raker MD		DEGREE		22c. DATE SIGNED 9/5/82				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANIL N. RAIKER MD		22e. ADDRESS GOOD SAMARITAN HOSPITAL Inc.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-9-82		23c. NAME OF CEMETERY OR CREMATORY McDowell Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE North Carolina			
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home, 7401 Belair Rd.				25a. DATE REC'D. BY REGISTRAR SEP 9 1982		25b. REGISTRAR'S SIGNATURE John J. Conner			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Failure to do so may result in the certificate being returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 2 7 1

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
LENA W. MARTIN		9 10 82		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	Jan. 22, 1886	96 YRS.	IF UNDER 24 HRS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	USA		Baltimore City MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Baltimore City Hospital		Homemaker		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS	
Md	-	Baltimore	1916 E. Fayette Street		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Louis W. Martin		Anna A. Lynch			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
no		215 34 6351	Anna W, Martin 5714 Greenspring Ave 21209		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Cardiovascular Disease</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>massive GI bleed</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Dementia, multiple cerebral infarcts, Seizures, pressure sores, hepatic failure</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (s) (this hospital) attended the deceased from <u>Nov 17</u> , 19 <u>76</u> , to <u>Sept 10</u> , 19 <u>82</u> , that (we) lost <u>above</u> <u>and</u> (the) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Vikas Sa</u>		MD		9-10-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
VIKAS SAINI		4940 Eastern Ave, Bowie, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION
Burial		9/11/82	Druid Ridge Cemetery		CITY OR TOWN COUNTY STATE
			Pikesville, Balto. Co. Md.		
24. FUNERAL DIRECTOR		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Burgee Funeral Home 3631 Falls Road 21211		SEP 14 1982		<u>John G. Calver</u>	

0604 BP

1

10-11-1931

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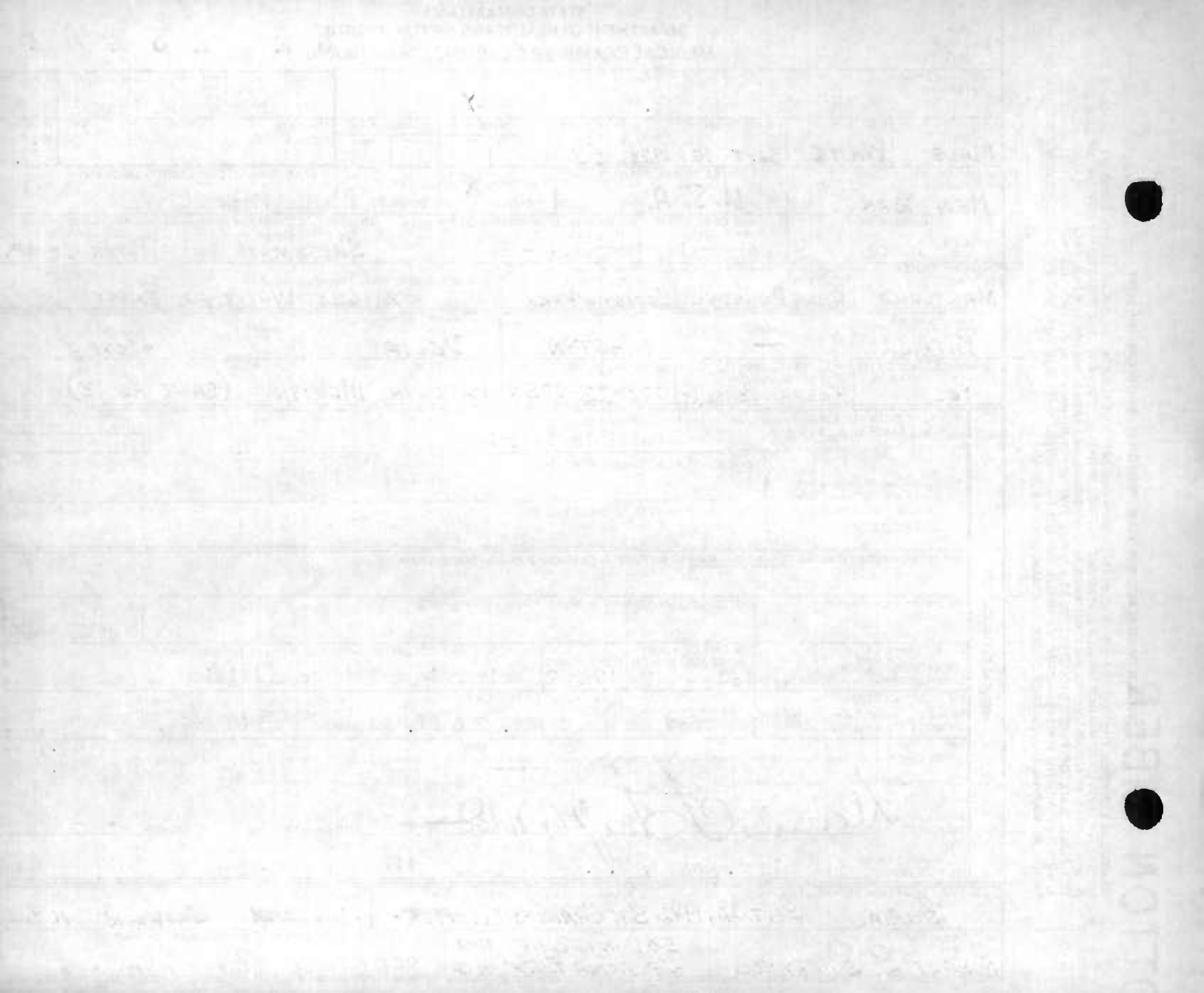
10-11-1931

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 7 2 2 3 2 7 2	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Raymond P. Martyn										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 15 1982	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR SEPT. 10 1929		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 15 1982		2d. HOUR 2:20 P.M.	
11. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital - STU				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY PAPER COMP.	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MARYLAND		13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN SEVERNA PARK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 628 WHITTIER PKWY.			
14. FATHER'S NAME FIRST MIDDLE LAST PATRICK - MARTYN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DELIA JOYCE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) YES KOREAN CONFLICT				16b. SOCIAL SECURITY NO. 078-22-2054		17. INFORMANT ADDRESS PATRICIA MARTYN (SAME AS 13)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries 8/20 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR 1:08 P.M. 9 15 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver in auto/auto collision					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 2 & Rt. 50 near Parole exit, Annapolis, Anne Arundel Co., Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Dennis F. Smyth, M.D.				TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 9-16-82			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE SEPT. 20, 1982		23c. NAME OF CEMETERY OR CREMATORY ST. CHARLES CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE PINELAWN SUFFOLK N.Y.			
24. FUNERAL DIRECTOR NAME ROBERT S. BARRANCO				ADDRESS 501 RITCHIE HWY. SEVERNA PARK, MD		25a. DATE REC'D. BY REGISTRAR SEP 20 1982		25b. REGISTRAR'S SIGNATURE J. J. Connelley			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked, item 18 sign only injury, or other traumatic event, the medical examiner must be notified above.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 2 3 2 7 3		
1. FOR STATE REGISTRAR												
1. DECEASED NAME (TYPE OR PRINT) Stanley Marzec						2a. DATE OF DEATH 9-28-82		2b. HOUR 9P				
3. SEX Male		4. RACE White		5. DATE OF BIRTH 3 13 09		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.						
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospitals				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman		12b. KIND OF BUSINESS OR INDUSTRY Steel				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3106 O'Donnell Street 21224		
14. FATHER'S NAME FIRST MIDDLE LAST Anthony Marzec						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Victoria						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 213-01-4181		17. INFORMANT ADDRESS Mrs. Violet A. Marzec, 3106 O'Donnell St. Baltimore, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 3320 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Parkinson's disease - no gag reflex.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>20 yrs.</u> Approximate interval between onset and death: <u>2 mrs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>8/13</u> , 19 <u>82</u> , to <u>9/28</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>9/28</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Pise M Chait MD						DEGREE MD			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Pise M Chait						22e. ADDRESS Baltimore City Hosp.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10-2-82		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Md.				
24. FUNERAL DIRECTOR Nicholas T. Matthews, 3021 Eastern Avenue Baltimore, Md.						25a. DATE REC'D. BY REGISTRAR OCT 1 1982		25b. REGISTRAR'S SIGNATURE John J. Conner				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 3 2 7 4	
FOR 1. STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) MARY LILLIAN MASHKES						2a. DATE OF DEATH MONTH DAY YEAR 09 - 06 - 82		2b. HOUR 11:05 A.M.			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 04 26 00		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
13a. STATE MARYLAND						13b. COUNTY		13c. CITY OR TOWN BALTIMORE			
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES ALTSCHUL						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLEN GOOD					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT ELLIS A. CAPLAN 3928 BRYONY RD. RANDALLSTOWN, MD 21133							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (b) ISCHEMIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) OLD CEREBRO VASCULAR ACCIDENT - COPD - OLD MYOCARDIAL INFARCTION											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: OLD CEREBRO VASCULAR ACCIDENT - COPD - OLD MYOCARDIAL INFARCTION											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 08 - 29 , 19 82 , to 09 - 06 , 19 82 , that (I) (we) last saw the deceased alive on 09 - 06 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If so, I did not view the body after death.)											
22b. SIGNATURE T. Tiffert				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 9/6/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TERESA TIFFERT				22e. ADDRESS SINAI HOSPITAL OF BALTIMORE							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE SEPT. 7, 1982		23c. NAME OF CEMETERY OR CREMATORY WORKMEN CIRCLE		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND					
24. FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR SEP 8 1982		25b. REGISTRAR'S SIGNATURE John J. Conick					

MEDICAL CERTIFICATION

29

BP

20/11/82 58-06-80 MARY

28 00 35 40

CARDIO-EMIT 2000
2000
OLD CEREAL VASCULAR INCIDENT - 2000

28-06-82 28-06-82 28-06-82

28/11/82 X
THERM THERM

28-06-82

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR				8 2 2 3 2 7 5 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN MATA				2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 26, 1982				2b. HOUR A M 7:22	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Feb. 21 1920		6 AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? U. S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Balto City MD.			
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Boner		12b. KIND OF BUSINESS OR INDUSTRY Esskay	
13a. STATE Md.				13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Felice Mata				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Roberti					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WW II 177-16-8433		17 INFORMANT ADDRESS Fannie M. Kaniecki 7 N. Curley St					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4920 IMMEDIATE CAUSE (a) Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema EMPHYSEMA DUE TO, OR AS A CONSEQUENCE OF (c) EMPHYSEMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour YEARS Years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a None NONE									
19a. DATE OF OPERATION NA N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 09-26-82 , 19____, to 09-26-82 , 19____, that (I) (we) lost saw the deceased alive on 09-26-82 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Bernard J. Yukna		DEGREE YUKNA				22c. DATE SIGNED 09-26-82		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD J. YUKNA		22e. ADDRESS CHURCH HOSPITAL 100 N. BROADWAY BALTO, MD 21231							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9-28-82		23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cem.		23d. LOCATION STREET CITY OR TOWN COUNTY STATE Balto. Md. COUNTY STATE			
24. FUNERAL DIRECTOR NAME Joseph N. Zannino Jr.		ADDRESS F.O.N. Conkling St		25a. DATE REC'D. BY REGISTRAR SEP 28 1982		25b. REGISTRAR'S SIGNATURE [Signature]			

DATE: 10-10-85

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

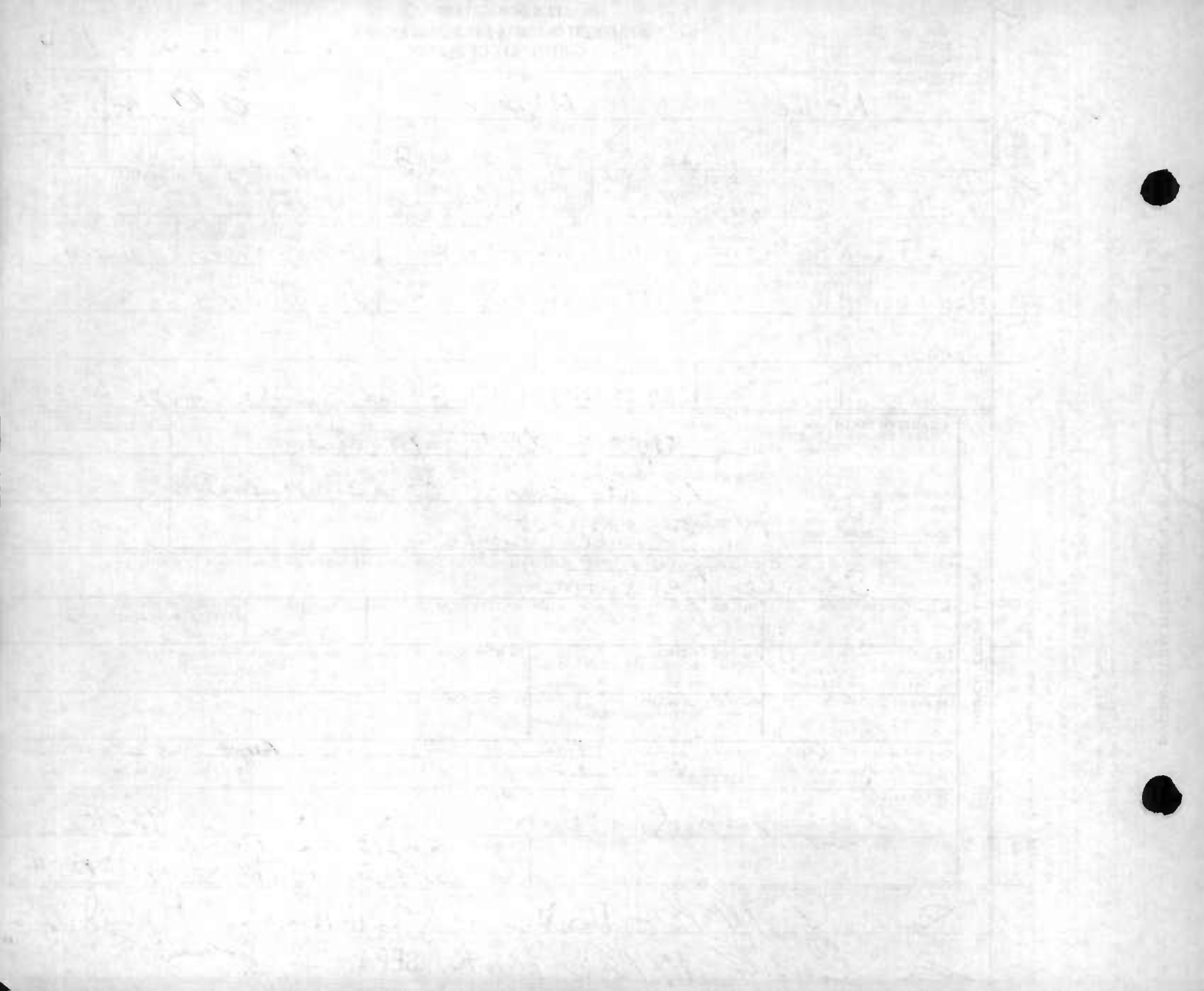
12. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be conducted.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nellie Maynor					2a. DATE OF DEATH MONTH DAY YEAR 9 9 1982		2b. HOUR P M 8:30 P M		
3. SEX FEMALE		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 4 9 1903		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 79 5		IF UNDER 1 YEAR IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KENSON NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSE WIFE		12b. KIND OF BUSINESS OR INDUSTRY NONE	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 802 WHITMORE AVE			
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS RUTH EXUMA 832 WHITMORE AVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Arterio sclerotic Cardiovascular Dis DUE TO, OR AS A CONSEQUENCE OF (c) Senile change. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: Senile Dementia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Feb. 19 79 to Augst 19 82 , that (I) (we) lost saw the deceased alive on August 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Schue-Yuan Liao, M.D.				DEGREE M.D.				22c. DATE SIGNED 9/10/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Schue-Yuan Liao				22e. ADDRESS Rm 215 Asler Med. Center 7600 Asler Drive, Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL Buried		23b. DATE 9/16/82		23c. NAME OF CEMETERY OR CREMATORY Mt. Vernon C.		23d. LOCATION CITY OR TOWN COUNTY STATE Lanark Maryland			
24. FUNERAL DIRECTOR NAME Eric Cunniff				ADDRESS 1712 W. North		25a. DATE REC'D BY REGISTRAR SEP 14 1982			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 2 7 7
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST Patricia H. McAllister AKA patricia H. Reed			2a. DATE OF DEATH MONTH DAY YEAR 9 10 82			2b. HOUR 2:14 AM	
3. SEX F Female		4. RACE W White		5. DATE OF BIRTH MONTH DAY YEAR 7 13 41		6. AGE (IN YEARS LAST BIRTHDAY) 41 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) TENNESSEE		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MARYLAND				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY	
12b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 3344 E. BALTIMORE ST. 21224							
14. FATHER'S NAME FIRST MIDDLE LAST HUBERT HENSLEY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDNA L GREGG			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 46S-64-7648		17. INFORMANT ADDRESS James R. McAllister - husband			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 5990 IMMEDIATE CAUSE (a) SHOCK DUE TO, OR AS A CONSEQUENCE OF SEPSIS (b) DUE TO, OR AS A CONSEQUENCE OF UTI (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) HEPATIC ENCEPHALOPATHY, DIC, SMALL BOWEL OBSTRUCTION							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Bruce S. Shames MD				DEGREE MD		22c. DATE SIGNED 9/10/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bruce S. Shames MD				22e. ADDRESS 22 S. GREENE ST BALTO, MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/14/82		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.	
24. FUNERAL DIRECTOR Schumaker Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213				25a. DATE REC'D. BY REGISTRAR SEP 14 1982		25b. REGISTRAR'S SIGNATURE John J. Lohr	

MEDICAL CERTIFICATION

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 2 7 8

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Mary M^cAuliffe		2a. DATE OF DEATH MONTH DAY YEAR Sept 2 82		2b. HOUR 8⁴⁵ A.M.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR MAR 10, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 89	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Knewick Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST John Claus Heinemann		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Hollstein			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-03-1297D		17. INFORMANT ADDRESS Mr. Walter Heinemann Sr. 1136 St. Agnes Lane	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4292 Cerebrovascular Accident IMMEDIATE CAUSE (a) ASCVD DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hrs. 8 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6 July 1982 to 2 Sept 1982 , that (I) (we) last saw the deceased alive on 2 Sept 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.					
22b. SIGNATURE Cherney D. Richardson M.D.				22c. DATE SIGNED 2 Sept 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Aubrey D. Richardson MD				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 4, 1982		23c. NAME OF CEMETERY OR CREMATORY New Cathedral	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.					
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck Inc. Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR SEP 3 1982		25b. REGISTRAR'S SIGNATURE John J. Connel	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

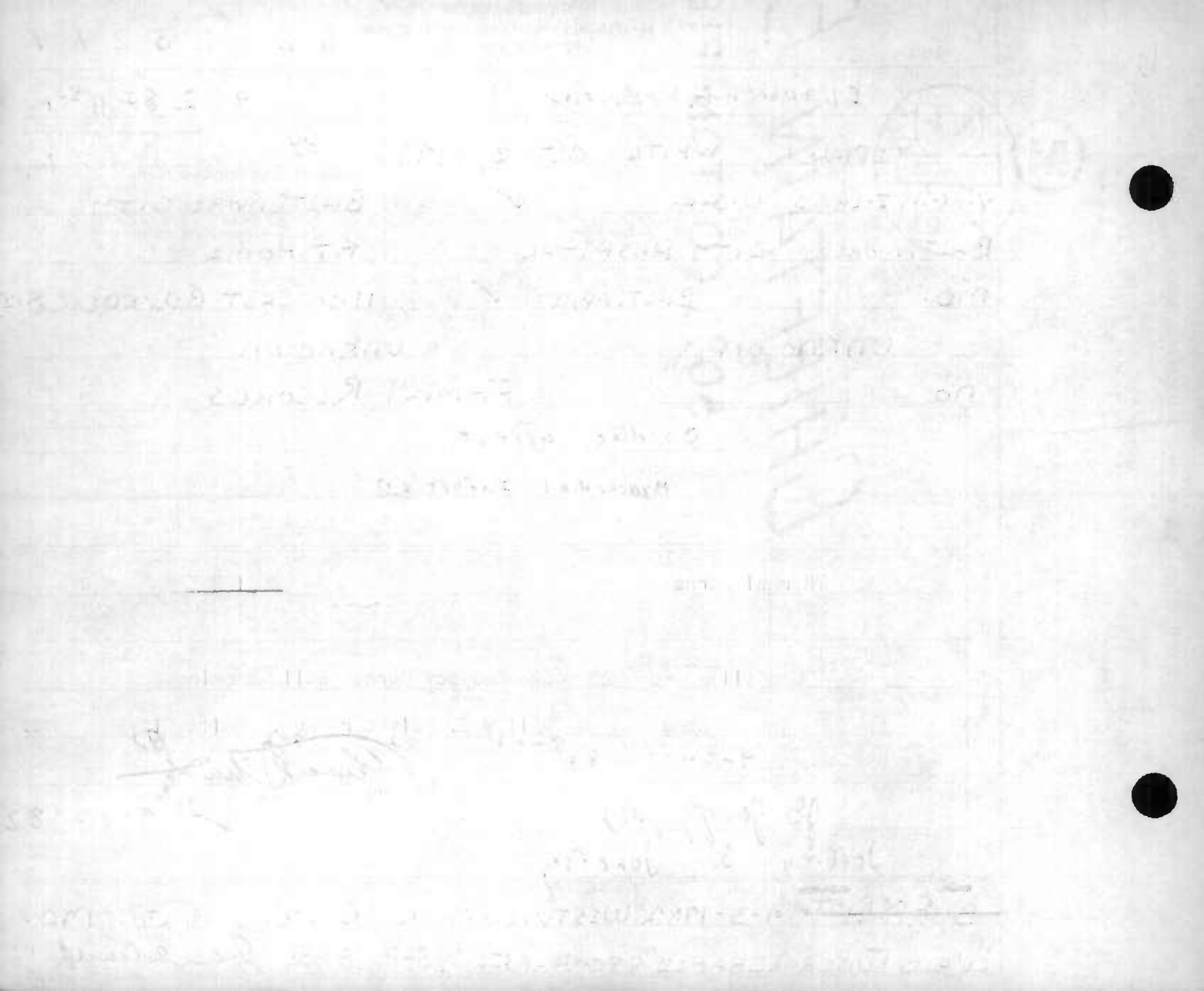
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B, shows any injury, or other traumatic event, the medical examiner must be notified and a death certificate must be filed with the medical examiner.

1. FOR STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 2 3 2 7 9 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Elizabeth G. McBrien		2a. DATE OF DEATH MONTH DAY YEAR 9 2 82	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCT. 3, 1897	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGIN ISLANDS		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 84 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITY HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MO.		13b. COUNTY BALTIMORE		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AT HOME	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN		13c. CITY OR TOWN BALTIMORE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS FAMILY RECORDS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Thermal Burns ACCIDENT					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR MONTH DAY YEAR 6:11 P.M. 8 25 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2) Subject burned while cooking	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) home		21f. LOCATION CITY OR TOWN COUNTY STATE 1100 E. Belvedere Ave. Balto. City, Md.	
22a. I certify that (I) (this hospital) attended the deceased from 9-22-82 to 9-22-82, that (I) (we) last saw the deceased alive on 9-22-82, and that in (my) (our) opinion, at the time and place stated, the causes stated were the causes of death.					
22b. SIGNATURE Jeffrey S. Janofsky, MD		DEGREE PHYSICIAN		CERTIFICATION APPROVED BY MEDICAL EXAMINER DATE SIGNED 9-22-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeffrey S. Janofsky		22e. ADDRESS			
23a. BURIAL CREMATION, OTHER SPECIFY: CREMATION		23b. DATE 9-3-1982		23c. NAME OF CEMETERY OR CREMATORY Westview Park	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. BALTO. MO.		23e. DATE REC'D. BY REGISTRAR SEP 8 1982		23f. REGISTRAR'S SIGNATURE John J. Conner	
24. FUNERAL DIRECTOR NAME EVANS FUNERAL CHAPIN		25. ADDRESS 8800 HARFORD			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed by a physician who attended the deceased within a hospital, or death certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper and place it in the envelope provided for the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 3 2 8 0 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) LEROY MCBRYDE						2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 29, 1982				2b. HOUR 1:08PM			
3. SEX male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 31 21		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		7. NUMBER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.							
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland						13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Josh McBryde						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST - - -							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] Yes				16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Glorious Reed 2613 Guilford Avenue							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4310 IMMEDIATE CAUSE (a) CARDIAL ARREST DUE TO, OR AS A CONSEQUENCE OF (b) BRAINSTEM HEMORRHAGE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) HYPERTENSION										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: -													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) this hospital attended the deceased from 9/27/82 , 19 82 , to 9/29/82 , 19 82 , that (I) (we) lost saw the deceased alive on 9/29/82 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE John W. Engstrom MD 22b. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN W. ENGSTROM						DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/29/82			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL						23b. DATE 10/4/82		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Av						25a. DATE REC'D. BY REGISTRAR SEP 30 1982		25b. REGISTRAR'S SIGNATURE John J. Smith					

11/11

NOV 11 1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 3 2 8 1 REG. NO.			
1. FOR STATE REGISTRAR				20. DATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Constance C McCauley</i>				MONTH DAY YEAR <i>9 1 82</i>			
2. SEX <i>Female</i>				2b. HOUR <i>11 P</i>			
3. RACE <i>White</i>				5. DATE OF BIRTH MONTH DAY YEAR <i>5 5 15</i>			
4. AGE (IN YEARS LAST BIRTHDAY) <i>67</i> YRS.				6. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>				7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Good Samaritan Hospital</i>			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Waitress</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>Resturant</i>			
13a. STATE <i>Maryland</i>				13b. COUNTY <i>-</i>			
13c. CITY OR TOWN <i>Baltimore</i>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS <i>3027 Huntingdon Avenue</i>							
14. FATHER'S NAME FIRST MIDDLE LAST <i>Thomas Hudson</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Addie V. Williams</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>217 03 2733</i>			
17. INFORMANT ADDRESS <i>Arthur M. McCauley 2919 Huntingdon Ave</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrest / hypotension</i> <i>3352</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>respiratory insufficiency</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>amyotrophic lateral sclerosis</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>9-1</i> , 19 <i>82</i> , to <i>9-1</i> , 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>9-1</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>C. Wm. Balke</i>				DEGREE <i>MD</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>9-1-82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>C Wm BALKE</i>				22e. ADDRESS <i>JOHNS HOPKINS HOSPITAL BALTI MD.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Entombment</i>		23b. DATE <i>9-4-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Mausoleum</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Pikesville, Balto, Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>Burgee Funeral Home, Baltimore, Maryland</i>				25a. DATE RECEIVED BY REGISTRAR <i>SEP 3 1982</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Canfield</i>	

1207 BP

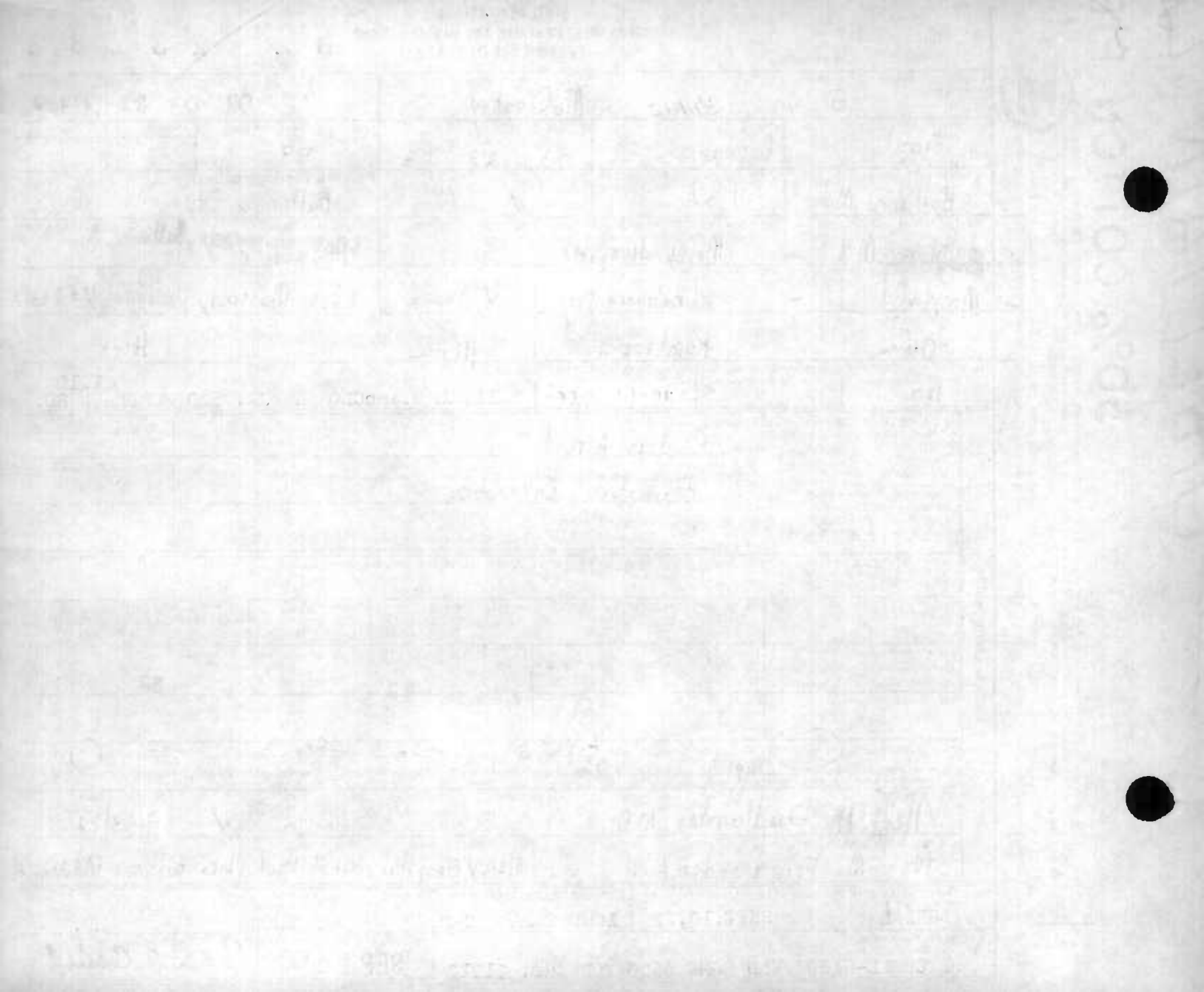
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8 2 2 3 2 8 2		REG. NO.							
I. DECEASED NAME (TYPE OR PRINT)		FIRST Evelyn		MIDDLE MARIC		LAST McCloskey		2a. DATE OF DEATH MONTH DAY YEAR 09 03 82		2b. HOUR 3:40 P.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 05 28 03		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md		9. CITIZEN OF WHAT COUNTRY? U.S.A		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
12. CITY OR TOWN OF DEATH Baltimore, Md		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		15. KIND OF BUSINESS OR INDUSTRY					
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland		16b. COUNTY -		16c. CITY OR TOWN Baltimore City		16d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16e. STREET ADDRESS 6306 Mossway, Baltimore, Md 21212			
17. FATHER'S NAME FIRST MIDDLE LAST OHO Kamborger		18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Heck		19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		20. SOCIAL SECURITY NO. 220-46-9256		21. INFORMANT WILLIAM B. McCLOSKEY JR.		22. ADDRESS 520 WOODLAWN RD. 21210	
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4349 Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF: (b) Brainstem Infarction DUE TO, OR AS A CONSEQUENCE OF: (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
23a. DATE OF OPERATION		23b. CONDITION FOR WHICH OPERATION WAS PERFORMED				23c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		23d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
24a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		24b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
25a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		25b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		25c. LOCATION STREET CITY OR TOWN COUNTY STATE							
26. I certify that (1) this hospital attended the deceased from August 29, 1982, to Sept 3, 1982, that (1) (we) lost now deceased after an above, (1) (we) (did) (did not) view the body after death, 19 02, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated											
27a. SIGNATURE Neal M. Friedlander, M.D.		27b. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		27c. DATE SIGNED 9/03/82							
27d. PHYSICIAN'S NAME (TYPE OR PRINT) Neal M. Friedlander, M.D.		27e. ADDRESS Mercy Hospital, 301 St. Paul Place, Baltimore, Md 21202									
28a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		28b. DATE SEPT. 10, 82		28c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEM.		28d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.					
29. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME		29b. ADDRESS 6500 YORK RD. 21212		29c. DATE REC'D. BY REGISTRAR SEP 14 1982		29d. REGISTRAR'S SIGNATURE John J. Conner					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR FILES TO FUNERAL DIRECTOR; PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

FOR cn 18 Film 572 10-27-82										STATE OF MARYLAND																																																	
1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE																																																	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 3 2 8 3																																																	
1. DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST					2a. DATE KNOWN OF DEATH					2b. MONTH DAY YEAR					2c. HOUR																																							
Jack					R. McClure					XX					9 12 19 82					M																																							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD					2d. HOUR																																										
M		WHITE		5 13 33		49 YRS.		MONTHS		DAYS		9 12 19 82					11:27 a M																																										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH																																												
OHIO					USA										Baltimore City, MD.																																												
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY																																												
Baltimore					1806 Ingram Road					CARPENTER					Building																																												
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET ADDRESS									
										MD.										-										BALTO										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										1806 Ingram Rd. 21239									
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)										16b. SOCIAL SECURITY NO.										17. INFORMANT										ADDRESS									
PAUL										CLEO										YES										219-28-0283										SHIRLEY McClure										1806 INGRAM RD. 21239									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART I DEATH WAS CAUSED BY:																																																											
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease																																																											
4292																																																											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last																																																											
(b)																																																											
DUE TO, OR AS A CONSEQUENCE OF																																																											
(c)																																																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																																											
Acute ethanol intoxication																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?																																							
																				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																																							
										P.M. 19																																																	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE																																							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																																											
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED																																							
Thomas D. Smith, M.D.										Deputy Chief										9/13/82																																							
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS										DATE SIGNED																																							
Thomas D. Smith, M.D.										111 Penn St. Balto., MD.																																																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION CITY OR TOWN COUNTY STATE																													
Burial										SEPT 16, 1982										Dulaney VALLEY										BALTO. MD.																													
24. FUNERAL DIRECTOR NAME										ADDRESS										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
HARTLEY Miller										7527 Harford Rd.										SEP 14 1982										John J. Canineh																													

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 3 2 8 4 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES L. MCCRAY				2a. DATE OF DEATH MONTH DAY YEAR 9 1 82		2b. HOUR 3:35 a	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1 16 43		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 39 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD	
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE MD.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Lawrence McCray				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Frazier			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 251-66-3588		17. INFORMANT ADDRESS Joanne Dorsey 1705 N. Ellamont St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Metastatic Squamous 1874 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA OF THE (c) PENIS							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 YRS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CONTRIBUTING TO DEATH							
19a. DATE OF OPERATION Feb 1981		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA OF PENIS		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from JAN 81 to Aug 27 19 82 , that (I) (we) lost saw the deceased alive on Aug 27 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE K. Shaw-Taylor				DEGREE MD		22c. DATE SIGNED 9/3/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. SHAW-TAYLOR				22e. ADDRESS UNIV of MD HOSPITAL, 22 S. Greene St			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/6/82		23c. NAME OF CEMETERY OR CREMATORY Jerusalem UM Church		23d. LOCATION CITY OR TOWN COUNTY STATE Salters S.C.	
24. FUNERAL DIRECTOR NAME Leroy Harris F/S 4520 Pen Lucy Road				25a. DATE REC'D. BY REGISTRAR SEP 7 1982			
				REGISTRAR'S SIGNATURE John J. Canfield			

MEDICAL CERTIFICATION

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TO THE SECRETARY OF THE INTERIOR
FROM THE DIRECTOR OF THE BUREAU OF LAND MANAGEMENT
SUBJECT: [Illegible]

1. [Illegible]
2. [Illegible]
3. [Illegible]

4. [Illegible]
5. [Illegible]
6. [Illegible]

7. [Illegible]
8. [Illegible]
9. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complies with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

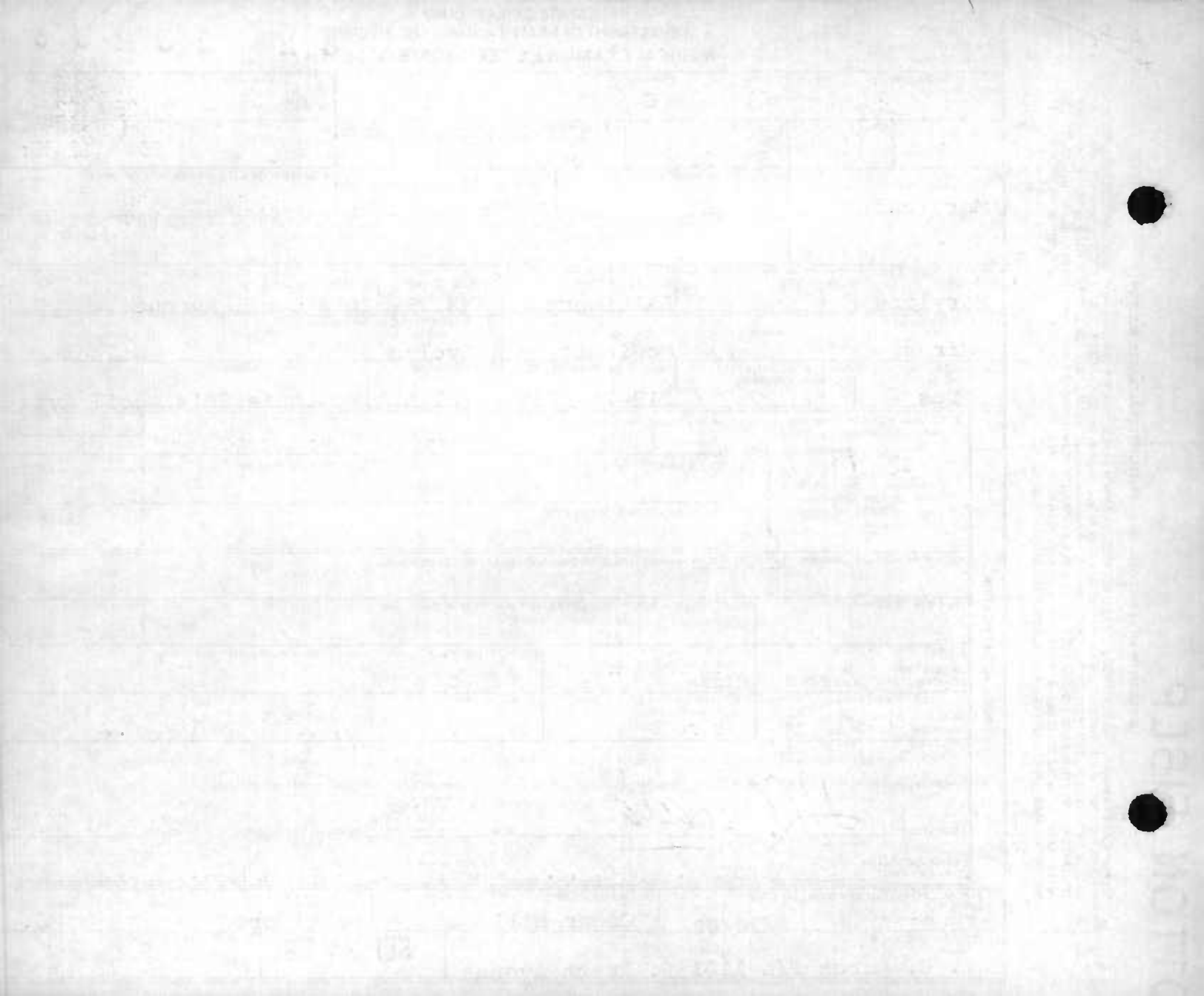
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 2 3 2 8 5			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 9-11-82			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LAWRENCE PAUL MCCARRITY				2b. HOUR 9:45 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 25, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Saint Agnes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Welder		12b. KIND OF BUSINESS OR INDUSTRY Coast Guard Yd.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Anne Arundel 13c. CITY OR TOWN Linthicum				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 503 Cheddington Road, 21090	
14. FATHER'S NAME FIRST MIDDLE LAST Edward McGarrity				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Clark			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. 213-10-3379		17. INFORMANT ADDRESS G. Doris McGarrity Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Lung Carcinoma							2 years
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2 August 19 82 to 11 September 19 82, that (I) (we) last saw the deceased alive on 10 September 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE OF THE PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL ELLIS, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9/14/1982		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Anne Arundel, Md.				23e. ADDRESS St. Agnes Hospital, Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME McCully Funeral Homes				24b. ADDRESS Balto. Md. 21225 237 E. Patapsco Ave.,		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 15 1982 John J. Conner	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 2 3 2 8 6	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Deryl (Daryl) G. Mc Ginnis										2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 9 25 19 82	
3. SEX male		4. RACE black		5. DATE OF BIRTH MONTH 5 DAY 31 YEAR 60		6. AGE (IN YEARS) (LAST BIRTHDAY) 22 YRS.		IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2614 Cecil Avenue			
14. FATHER'S NAME FIRST Mires MIDDLE McGinnis LAST Wilson						15. MOTHER'S MAIDEN NAME FIRST Evelyn MIDDLE Wilson LAST Wilson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-76-3365				17. INFORMANT Evelyn A. McGinnis ADDRESS 2614 Cecil Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9654 IMMEDIATE CAUSE (a) Gunshot wound of head Weapon: Unspecified Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:57 AM 9/25 19 82				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street				21f. LOCATION STREET 1442 N. Broadway, CITY OR TOWN Baltimore COUNTY City, STATE MD.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE H. R. Guard				M.D. Assistant				DATE SIGNED 9/26/82			
EXAMINER'S NAME (TYPE OR PRINT) Horemz R. Guard, M.D.				ADDRESS 111 Penn Street, Balto., MD 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 9/30/82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem				23d. LOCATION CITY OR TOWN Baltimore COUNTY MD.	
24. FUNERAL DIRECTOR NAME Wm. C. March F/h ADDRESS 1101 E. North Avenue						25a. DATE REC'D BY REGISTRAR SEP 27 1982		25b. REGISTRAR'S SIGNATURE John J. Carver			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Filled, signed, and returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been filled out by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. This permit will be returned to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8 2 2 3 2 8 7 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
LOUISE						McGOINES (COLEMAN)		SEPTEMBER 01, 1982		11:30A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		BLACK		MONTH DAY YEAR 07 24 1895		87 YRS		MONTHS DAYS		HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
md.		U.S.A.				BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		THE JOHNS HOPKINS HOSPITAL						Ret.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
md.				BALTO.				3433 Piedmont Ave.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
William		Lucy		NO		220-30-2015		Ms. Edna Coleman - 3433 Piedmont Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
5860 IMMEDIATE CAUSE (a) seizure / cardiac arrest											
DUE TO, OR AS A CONSEQUENCE OF (b) renal failure / mitral regurgitation											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 8/30, 19 82, to 9/1, 19 82, that (we) last saw the deceased alive on 8/30, 19 82, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
Eric J. Seifter								9/1/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
ERIC J. SEIFTER		JOHNS HOPKINS HOSPITAL									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		9-4-82		ARBUTUS Mem. PK.		ARBUTUS		md.			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Redd FUNERAL Home		5209 YORK Rd.		BALTO. md.		SEP 7 1982		John J. Conner			

Source

Franklin D. Roosevelt

1941

The Roosevelt Hospital

NY

No



NOV 10 1941

U.S. Department of Health

Division of Hygiene and Prevention

U.S. Department of Health, Education and Welfare

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

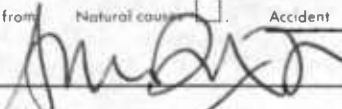
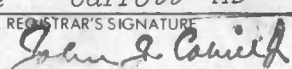
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 3 2 8 8	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Carletter L. McGruder					2a. DATE OF DEATH MONTH DAY YEAR 9-23-82			2b. HOUR 8:45 M			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 4 24 06		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY Private			
13a. STATE Md.					13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Isiah Green					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AMY Burnett						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. ?		17. INFORMANT ADDRESS Mrs. Mattie Brown 2625 E. Preston St.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest 1830 DUE TO, OR AS A CONSEQUENCE OF (b) Cancer ovary mta metastasis, R/o sepsis DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE S. Suwanapool						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Suwanapool						22e. ADDRESS Lutheran Hospital MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9-27-82		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus MD.			
24. FUNERAL DIRECTOR NAME Randolph J. Collick						ADDRESS 2431 E. Oliver St		25a. DATE REC'D. BY REGISTRAR SEP 28 1982		25b. REGISTRAR'S SIGNATURE John J. Canine	

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		2 2 3 2 8 9	
1. DECEASED NAME (TYPE OR PRINT) BRIAN PATRICK MC GUINNESS			
2. SEX Male		2b. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 4 19 82	
4. RACE White		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 4 19 82	
5. DATE OF BIRTH MONTH DAY YEAR 12 13 1957		2d. HOUR 2:56	
6. AGE (IN YEARS LAST BIRTHDAY) 24 YRS.		7. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. CITY OR TOWN OF DEATH Baltimore	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital (DOA)	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed	
13a. STATE MD		13b. CITY OR TOWN Baltimore	
13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 7308 Dooman Rd. 21207	
14. FATHER'S NAME FIRST MIDDLE LAST Francis X. McGuinness		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jean R. Rasmussen	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-76-2649	
17. INFORMANT Mr. and Mrs. Francis X. McGuinness		ADDRESS 7308 Dooman Rd., Baltimore, MD 21207	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cranio-cerebral trauma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:29 PM 9-4-1982	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN STATE Liberty Rd. e. of Randallstown, Balto. Md.	
22a. I certify that I took charge of the remains described above, held on death resulted from <input type="checkbox"/> Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		DATE SIGNED 9-4-82	
ADDRESS 111 Penn St., Balto., Md. 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/8/82	
23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll MD	
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc.		25a. DATE REC'D. BY REGISTRAR SFP 7/1982	
ADDRESS 8728 Liberty Road, Randallstown, MD 21133		25b. REGISTRAR'S SIGNATURE 	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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100-100000-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8 2 2 3 2 9 0 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
David Joseph McGUIRE								9-15-82		4:30 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 72 HRS. HOURS MIN.	
Male		White		4-14-89		73 76 YRS.					
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MD		USA				Baltimore City MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Lutheran Hospital						Mechanical		Lyon Co.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
MD				Baltimore				2518 Bridge Dr 21230			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
James Joseph McGUIRE		Lillian Gurlach									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
NO		21098738		Doreen Jones McGUIRE 7818 Bridge Drive 21226							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Cardiorespiratory failure											
1509 DUE TO, OR AS A CONSEQUENCE OF (b) Same.											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma oesophagus.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Carcinoma oesophagus.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
9/6/82		Ca oesophagus									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 9/13/82, 1982, to 9/15/82, 1982, that (I) (we) last saw the deceased alive on 9/15, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED					
J. SINGH		MD				9/15/82					
23a. PHYSICIAN'S NAME (TYPE OR PRINT)		23b. ADDRESS									
J. SINGH		Lutheran Hospital									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		9-18-1982		New Calhoun Cem.		Baltimore MD.					
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
JOHN J. COWAN		2101 N. WILKINS ST.		SEP 17 1982		John J. Cowan					

[Faint, illegible handwriting on lined paper, possibly bleed-through from the reverse side. The text is mostly obscured by the quality of the scan and the faintness of the ink.]



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 2 9 1

REG. NO.

1- FOR
STATE
REGISTRAR

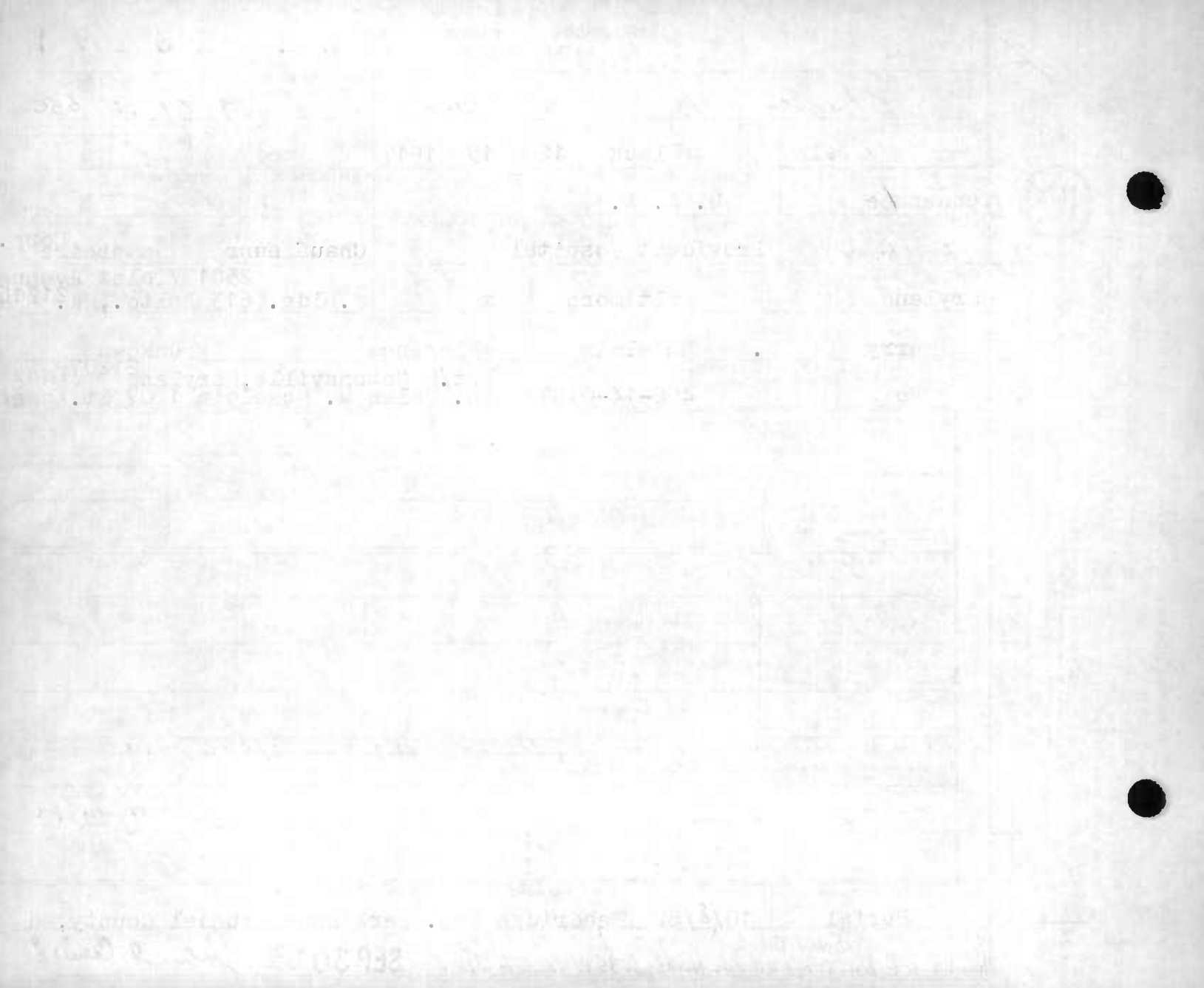
1. DECEASED NAME (TYPE OR PRINT) <i>Charles H McKeldin</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>9 29 82</i>		2b. HOUR <i>650 M</i>
3. SEX <i>Male</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>12 15 1917</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>64</i> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Tennessee</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Provident Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Chauffeur</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Hampshire Corp.</i>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Harry W. McKeldin</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Florence Unknown</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>408-14-01074</i>		17. INFORMANT NAME ADDRESS <i>Mrs. Helen M. McKeldin 1207 St. Agnes</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY <i>Ca esophagus</i> IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>9/27</i> , 19 <i>82</i> , to <i>9/29</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>9/29</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Mohamen</i>		DEGREE		22c. DATE SIGNED <i>9/29/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Mohamen</i>		22e. ADDRESS <i>Provident Hospital</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>10/4/82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Meadridge Mem. Park</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i>		23e. NAME OF CEMETERY OR CREMATORY <i>Arundel County, Md</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>Herbert E. Nutter Funeral Home 3035 W. NORTH AVE.</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 30 1982</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 2 9 2

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Baby JAMES Boy MICHAEL McKenna			2a. DATE OF DEATH MONTH DAY YEAR Sept. 10 1982			2b. HOUR 231 P.M.					
3. SEX Male		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 9-10-82		6. AGE (IN YEARS LAST BIRTHDAY) — YRS. MONTHS DAYS — — 2 30		IF UNDER 1 YEAR IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTO. CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL, INC.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NEWBORN		12b. KIND OF BUSINESS OR INDUSTRY —			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.			13b. CITY OR TOWN BALTO. CITY			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d. STREET ADDRESS 529 N. LINWOOD AVE #81205		
14. FATHER'S NAME FIRST MIDDLE LAST JAMES MICHAEL LONGDON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KAREN MCKENNA			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. —	
17. INFORMANT ADDRESS WILLIAM F. MCKENNA - 529 N. LINWOOD AVE. #81205											

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST 7488			
DUE TO, OR AS A CONSEQUENCE OF (b) INABILITY TO VENTILATE LUNGS			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
DUE TO, OR AS A CONSEQUENCE OF (c) COMPLAINT ATLECTASIS OF LUNGS			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
POSSIBLE POTTER'S SYNDROME

19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9/11 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/11 19 82 , to 9/11 19 82 , that (I) (we) last saw the deceased alive on 9/11 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Benson M. Silverman M.D.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/11/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BENSON M. SILVERMAN		22e. ADDRESS MERCY HOSPITAL, INC. 301 ST. PAUL PL. BALTO. MD. 21202					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 09/13/82		23c. NAME OF CEMETERY OR CREMATORY SACRED HEART OF JESUS		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE COUNTY MD.	
24. FUNERAL DIRECTOR NAME George A. Weber & Son, Inc. - 705 S. Ann St. ADDRESS				25a. DATE REC'D. BY REGISTRAR SEP 15 1982		25b. REGISTRAR'S SIGNATURE Sam J. Carver	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 2 9 3

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) BRENDA MCKENNEY			2a. DATE OF DEATH MONTH DAY YEAR 9 18 82			2b. HOUR 16 40 M			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 22 61		6. AGE (IN YEARS LAST BIRTHDAY) 21 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST John McKennedy			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martin			16. STREET ADDRESS 4003 Crawston Avenue			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT John McKennedy 4003 Crawston Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adult Respiratory Distress Syndrome 6714 DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Pelvic Thrombophlebitis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days 9 days 1 month								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Gun trauma	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/18/82 19 to 9/18/82 19, that (I) (we) last saw the deceased alive on 9/18/82 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Kamal J. Dotrin				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/18/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KAMAL J. DOTRIN				22e. ADDRESS % Union Memorial Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/23/82		23c. NAME OF CEMETERY OR CREMATORY Mount Zion Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North Avenue				25a. DATE RECEIVED BY REGISTRAR SEP 23 1982		25b. REGISTRAR'S SIGNATURE John J. Canine			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 23295	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GERTRUDE Kane MEAGHER						2a. DATE OF DEATH KNOWN <input type="checkbox"/> OF ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 4 19 82		2b. HOUR M			
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 1---24---01	6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 81	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 5 19 82		2d. HOUR a M 10:36			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1900 Dixon Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY -----			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1900 Dixon Rd 21209			
14. FATHER'S NAME FIRST MIDDLE LAST Patrick Kane				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Vahey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-36-9537		17. INFORMANT ADDRESS J. Carbry Meagher 2 Ranger Ct 21234							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4029 IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Anemia											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Ann M. Dixon, M.D.				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 9-7-82			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-8-82		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home						ADDRESS 6500 York Rd 21212		25a. DATE REC'D. BY REGISTRAR SEP 10 1982		25b. REGISTRAR'S SIGNATURE J. Carver	

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

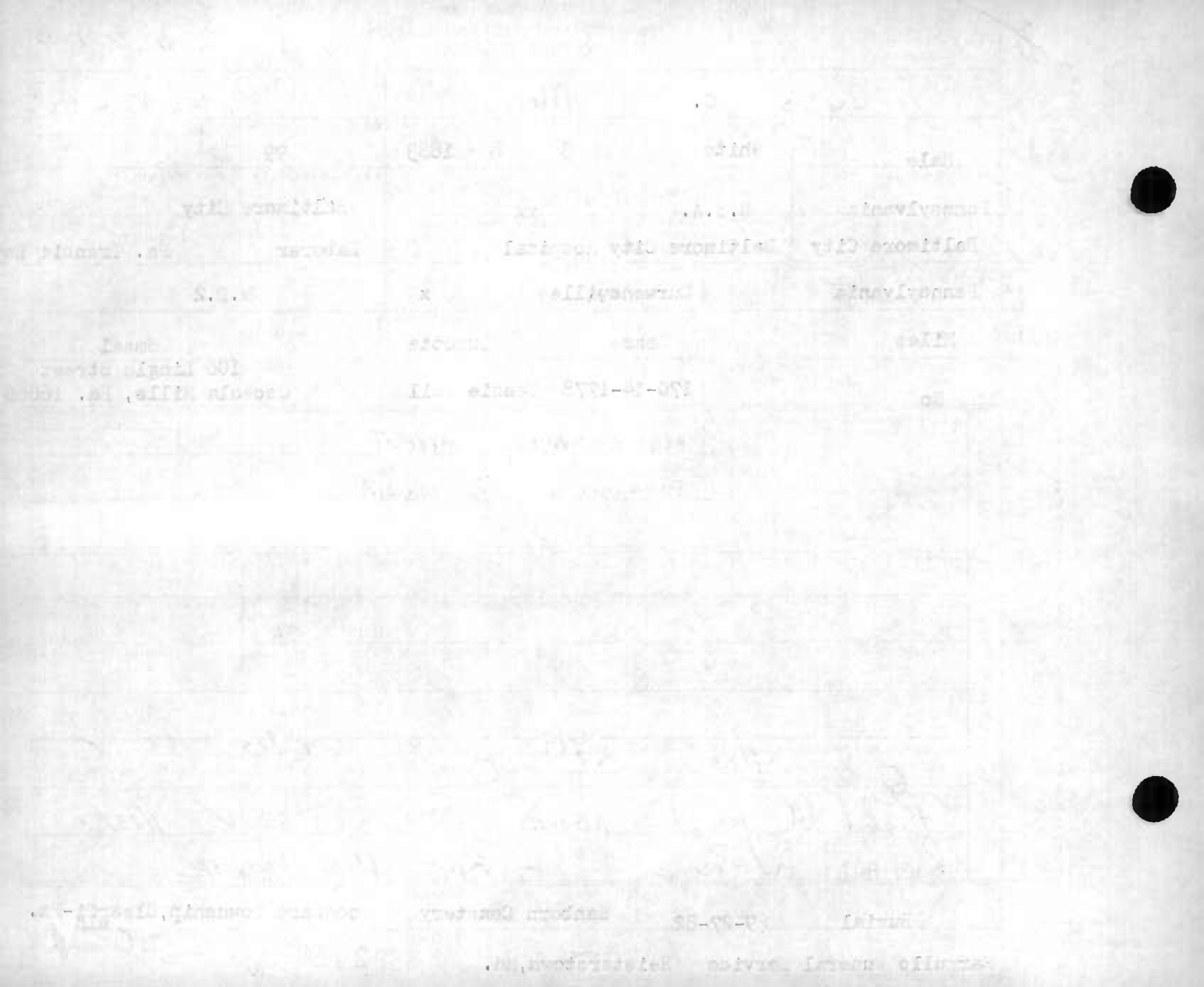
FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 2 9 6
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Cyrus G. Mease			2a. DATE OF DEATH MONTH DAY YEAR 9 23 82		2b. HOUR 6:10 P.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 8 1883		6. AGE (IN YEARS LAST BIRTHDAY) 99 YRS
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Pa. Transit Dep.
13a. STATE Pennsylvania		13b. COUNTY Curwensville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS R.D.2
14. FATHER'S NAME FIRST MIDDLE LAST Miles Mease			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Luzetta Smeal			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 170-14-1778		17. INFORMANT Bessie Vail		ADDRESS 106 Lingle Street Osceola Mills, Pa. 16666
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) CALDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) PNEUMONICAL PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 9/19 , 19 82 , to 9/23 , 19 82 , that (I) (we) last saw the deceased alive on 9/23 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Richard A. Joseph		DEGREE MS MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/23/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD A. JOSEPH			22e. ADDRESS BALT City Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-27-82		23c. NAME OF CEMETERY OR CREMATORY Sanborn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Woodward Township, Clearfield Pa.
24. FUNERAL DIRECTOR NAME Marzullo Funeral Service			ADDRESS Reisterstown, Md.		25a. DATE REC'D. BY REGISTRAR SEP 24 1982	
25b. REGISTRAR'S SIGNATURE John J. Connel						

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be filed with the death certificate.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 3 2 9 7 REG. NO.			
1. FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES F. MECHLINSKY						2a. DATE OF DEATH MONTH DAY YEAR 09 03 82				2b. HOUR A_M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 7 6 14		6. AGE (IN YEARS LAST BIRTHDAY) 68		IF UNDER 1 YEAR MONTHS DAYS YRS.		IF UNDER 24 HRS. HOURS MIN MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.							
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1638 COLE STREET, 21223						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical Work		12b. KIND OF BUSINESS OR INDUSTRY Westinghouse			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1638 Cole Street 21223					
14. FATHER'S NAME FIRST MIDDLE LAST James S. Mechlinsky						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary J. Ogle							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT Susanna Mechlinsky		ADDRESS 1638 Cole Street 21223							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4100 Myocardial infarction IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Myocardial infarction													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 6/30 , 19 82 , to 7/2 , 19 82 , that (I) (we) lost saw the deceased alive on 7/2 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE James Evans M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/5/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES EVANS, M.D.						22e. ADDRESS WASHINGTON VILLAGE COMMUNITY MED. CTR. 700 WASHINGTON BOULEVARD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/7/82		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Mausoleum		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland							
24. FUNERAL DIRECTOR NAME ADDRESS HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.						25. DATE REC'D. BY REGISTRAR SEP 7 1982		26. REGISTRAR'S SIGNATURE John J. Carter					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PHA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 3 2 9 8			
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Richard Michael Meehan Sr.										DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 26 19 82		2b. HOUR 2:A	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 10 43		6. AGE (IN YEARS LAST BIRTHDAY) 38 YRS.		7. IF UNDER 1 YR. MONTHS DAYS		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 26 19 82		2d. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5800 Reisterstown Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Asst. Manager		12b. KIND OF BUSINESS OR INDUSTRY Kent. Fried			
13a. STATE Maryland				13b. CITY OR TOWN Sykesville		13c. STREET ADDRESS 1108 Canterbury Court		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21784			
14. FATHER'S NAME FIRST MIDDLE LAST Lawrence E. Meehan						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine G. Guercio							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 220-42-6212		17. INFORMANT Mrs. Joy L. Meehan				ADDRESS Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9654 IMMEDIATE CAUSE (a) Multiple gunshot wounds Weapon: Unspecified Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:40 AM 9/26 19 82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot							
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) restaurant /Gino's		21f. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, MD							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Hormez R. Guard, MD..				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER DATE SIGNED 9/26/82					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 111 Penn Street, Balto., MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9/29/82		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Towson Md.					
24. FUNERAL DIRECTOR NAME Witzke P.A.				ADDRESS 21228		25a. DATE RECEIVED BY REGISTRAR SEP 28 1982		25b. REGISTRAR'S SIGNATURE					
1630 Edmondson Avenue, Catonsville, Maryland													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		8 2 2 3 2 9 9 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN ADAM MEHL JR.						2a. DATE OF DEATH MONTH DAY YEAR SEPT. 16 1982		2b. HOUR 2:30 P.M.	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 02 07 22		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MACHINIST		12b. KIND OF BUSINESS OR INDUSTRY PUBLIC WORKS	
13a. STATE MARYLAND						13b. COUNTY ---		13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN A. MEHL SR.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVELYN I. SULLIVAN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS MIRIAM MEHL 2013 MAISEL STREET, 21230					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE PULMONARY EMBOLUS</u> 4371 DUE TO, OR AS A CONSEQUENCE OF (b) <u>WEAKNESS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>POSSIBLE CEREBRAL ISCHEMIA</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS DAYS 10 DAYS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE James S. Taylor				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 9/17/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES E. TAYLOR				22e. ADDRESS ST AGNES HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 09-20-82		23c. NAME OF CEMETERY OR CREMATORY CROWNSVILLE VETERANS		23d. LOCATION CITY OR TOWN COUNTY STATE CROWNSVILLE A.A. MARYLAND			
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.				ADDRESS 21229 4107 WILKENS AVE.		25a. DATE REC'D. BY REGISTRAR SEP 20 1982		25b. REGISTRAR'S SIGNATURE John J. Conner	

8



RECEIVED



SEP 20 1952

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE FILES AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 2 3 3 0 0									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mark E. Mende										2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 9 18 19 82		2b. HOUR M							
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 21 62		6. AGE (IN YEARS LAST BIRTHDAY) 20 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 9 18 19 82		2d. HOUR 11:05 a. M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.							
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital - STU				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assembler				12b. KIND OF BUSINESS OR INDUSTRY Constru							
13a. STATE Maryland				13b. COUNTY Frederick				13c. CITY OR TOWN Walkersville				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 9417 Glade Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST Gayhart William Mende Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Jane Laisure				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 220-78-8201				17. INFORMANT ADDRESS Mary Shelton, 9417 Glade Ave., Walkersville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 88+4 IMMEDIATE CAUSE (a) Thoraco-abdominal injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9:15xx 9 18 19 82				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject fell from silo											
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Farm				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Lemuel Kinnanion Farm, Ingleside, Queen Anne's Co., Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 9-19-82							
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9/22/82				23c. NAME OF CEMETERY OR CREMATORY Glade Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Walkersville, Frederick, Md							
24. FUNERAL DIRECTOR NAME G. Douglas Stauffer				1621 Opossumtown Pike Frederick, Md.				25a. DATE REC'D. BY REGISTRAR SEP 29 1982				25b. REGISTRAR'S SIGNATURE <i>J. J. Grief</i>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					8 2 2 3 3 0 1 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Julia D. MERRIAM					2a. DATE OF DEATH MONTH DAY YEAR September 13, 1982			2b. HOUR 1:27p M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 12 1894		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dentist Assistant		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Balto., Md. 21230 643 Washington Blvd.	
14. FATHER'S NAME FIRST MIDDLE LAST Fred S		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louisa Koch		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					
16b. SOCIAL SECURITY NO. 212-36-0459		17. INTERMENT ADDRESS 4315 Cross Country Dr., Ellicott Mr. Robert F. Merriam City, Md. 21043							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pancreatic carcinoma (In-operable) 1579 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 11, 1982, to September 13, 1982, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on September 13, 1982, and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE Michael Hyle, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/13/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Hyle, M.D.				22e. ADDRESS c/o Maryland General Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-16-82		23c. NAME OF CEMETERY OR CREMATORY Lorraine Pk. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			
24. FUNERAL DIRECTOR G. Truman Schwab, P.A.		5151 Balto. Nat'l. Pike #21229		25a. DATE REC'D. BY REGISTRAR SEP 20 1982					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be enclosed for use on the burial/transport permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR - STATE REGISTRAR									
2. REG. NO. 8 2 2 3 3 0 2									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN MESSORIS SR.					2a. DATE OF DEATH MONTH DAY YEAR 9/5/82		2b. HOUR 808 PM		
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 10 1 21		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA.		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD			
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITY HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BETH. STEEL		12b. KIND OF BUSINESS OR INDUSTRY STEEL	
13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN DUNDALK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1913 HAZEL MERE RD.	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST THERESA Bodi							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT NAME IRENE MESSORIS		ADDRESS SAME			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) CARDIAC ARREST MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONITIS DUE TO, OR AS A CONSEQUENCE OF (c) SQUAMOUS CARCINOMA OF LUNG 5 mos.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a ADENO CARCINOMA OF LUNG (RESECTED) 1980.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR: A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) this hospital attended the deceased from 9/1 19 82 Jan 19 1982 to 9/5 19 82, that (I) (we) last saw the deceased alive on 9/1 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J.C. Keogh M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES P. KEOGH M.D.				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/9/82		23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD			
24. FUNERAL DIRECTOR NAME CONNELLY FUNERAL HOME OF DUNDALK				25a. DATE RECD. BY REGISTRAR SEP-9-1982		25b. REGISTRAR'S SIGNATURE John J. Carney			

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 3 0 3

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) RAYMOND C. METZ			2a. DATE OF DEATH MONTH DAY YEAR 9-03-82		2b. HOUR 1030 A.M.
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR July 1, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospitals		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver	
13a. STATE Baltimore		13b. COUNTY ---	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lydia Young		13e. STREET ADDRESS 3400 Eastern Ave. #21224	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 282-16-8124		17. INFORMANT ADDRESS Lolita Kirby - 521 Standish N.W. - Ohio 44646	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) cardiac pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) septicemia DUE TO, OR AS A CONSEQUENCE OF (c) colon carcinoma					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25 min rest 2 days unknown
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
20. I certify that (a) this hospital attended the deceased from 9-02 19 82 , to 9-03 19 82 , that (b) (we) lost saw the deceased alive on 9-03 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22a. SIGNATURE Jeffrey L. Moore MD		DEGREE		22c. DATE SIGNED 9-03-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JEFFREY MOORE MD		22e. ADDRESS 4940 Eastern Avenue - Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 9/9/82		23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Md.		23e. NAME OF REGISTRAR John J. Carver			
24. FUNERAL DIRECTOR NAME George A. Weber & Sons Inc. - 705 S. Ann St.		25a. DATE REC'D. BY REGISTRAR SEP 9 1982			

MEDICAL CERTIFICATION

2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Items 13a-e per phone 10/8/82 day STATE OF MARYLAND

FOR
1- STATE
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 3 0 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Baby Girl "B" Katherine Anne Meushaw		2a. DATE OF DEATH MONTH DAY YEAR 9-24-82		2b. HOUR 11 ¹⁰ P.M.	
3. SEX Girl	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9-24-82		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 1	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? St. Agnes	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. CITY OR TOWN Howard	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS 4188 Brittany Lane 21043	
14. FATHER'S NAME 14a. FIRST MIDDLE LAST Robert V. Meushaw		15. MOTHER'S MAIDEN NAME 15a. FIRST MIDDLE LAST Kathleen Elizabeth Meushaw			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Robert Meushaw 4188 Brittany Dr. 21043	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 7650 IMMEDIATE CAUSE (a) <u>swen immaturity, cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Salcedo</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) U. T. SALCEDO		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SEE FOOTNOTES) Burial		23b. DATE Oct 4, 1982		23c. NAME OF CEMETERY OR CREMATORY St Johns	
23d. LOCATION Baltimore City Howard Md. STATE					
24. FUNERAL DIRECTOR NAME Harry H Witzke 4112 Columbia Rd		25a. DATE REC'D. BY REGISTRAR OCT 7 1982		25b. REGISTRAR'S SIGNATURE John J. Connel	

BP

MOORE, MARY J.

RECEIVED

MAILED
OCT 19 1902
MISSOURI CITY, MISSOURI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

Items 13a-e per phone 10/8/82 <small>STATE OF MARYLAND</small>									
DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
REG. NO. 8 2 2 3 3 0 5									
1. DECEASED NAME (TYPE OR PRINT) BABY GIRL "A" (MARGARET ELIZABETH) MEUSHAW						2a. DATE OF DEATH MONTH 9 DAY 25 YEAR 82		2b. HOUR 6.55 P M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 9 DAY 24 YEAR 82		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS		IF UNDER 1 YEAR MONTHS DAYS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.						13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City	
14. FATHER'S NAME (FIRST) ROBERT (MIDDLE) V. (LAST) MEUSHAW						15. MOTHER'S MAIDEN NAME (FIRST) KATHLEEN (MIDDLE) ELIZABETH (LAST) MEUSHAW			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Robert Meushaw 4188 Brittany Drive 21043					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7651 IMMEDIATE CAUSE (a) Cardio respiratory arrest								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) severe immaturity									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>U. T. SALCEDO</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) U. T. SALCEDO				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (IF ANY) Burial		23b. DATE Oct 4, 1982		23c. NAME OF CEMETERY OR CREMATORY St Johns Cemetery		23d. LOCATION Ellicott City, Howard, Md.			
24. FUNERAL DIRECTOR NAME Harry H Witzke 4112 Columbia Rd				25a. DATE REC'D. BY REGISTRAR OCT 7 1982		25b. REGISTRAR'S SIGNATURE <i>John J. [Signature]</i>			

2



Harry H. White and Columbia Illinois City
Printed Oct. 1982 St. Louis, Missouri
Illinois City, Missouri, Mo.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
20M 4/B2

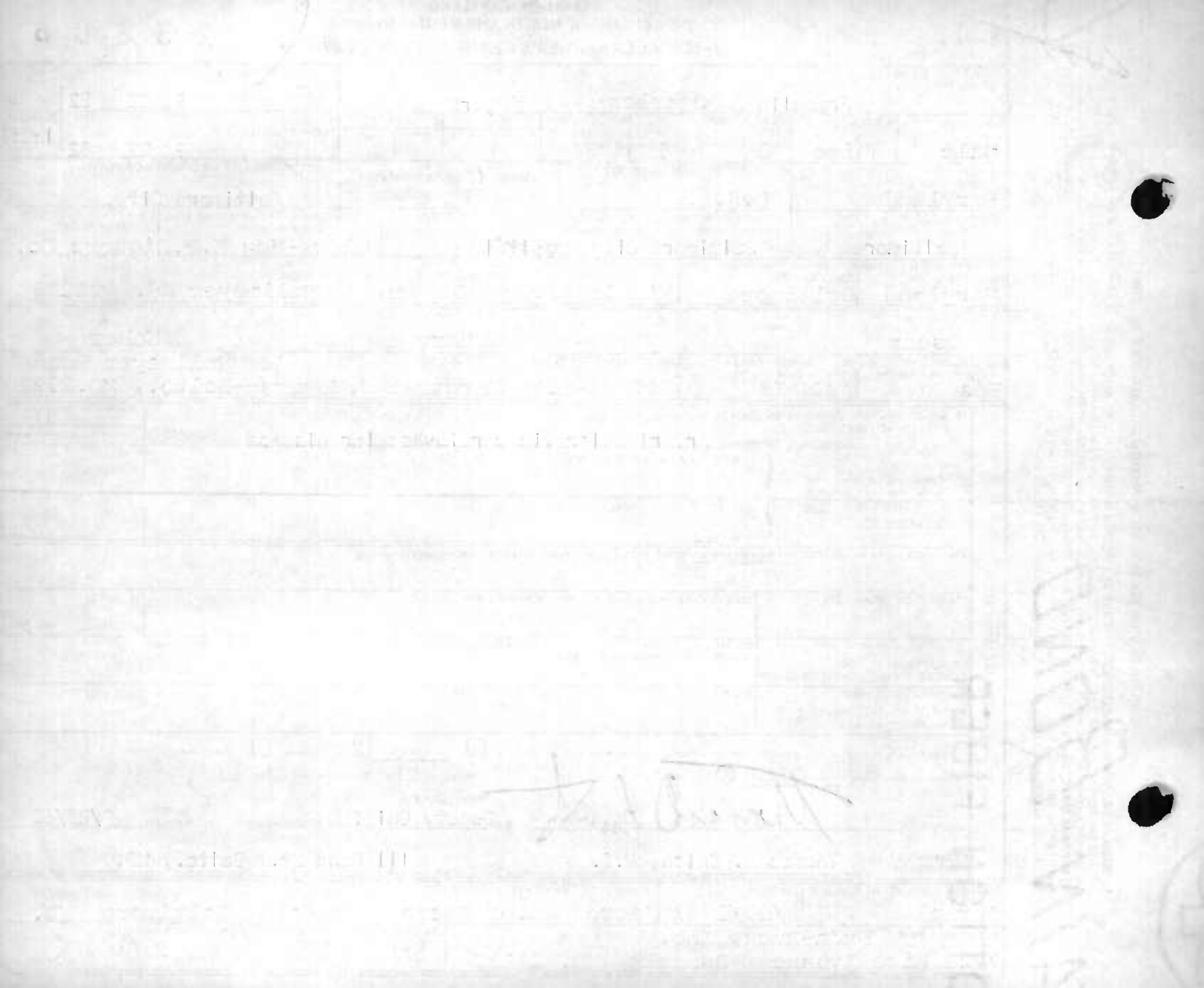
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Franklin Charles Meyers						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 22 19 82			2b. HOUR M 1:25 PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 2 18 64 YRS.		6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 22 19 82		7d. HOUR M 1:25 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.				10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital			
12a. USUAL RESIDENCE (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk-New N.P. Liquors Co.				12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12c. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland				13b. CITY OR TOWN Baltimore				13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13d. STREET ADDRESS 404 Nollmeyer Rd. 21220				14. FATHER'S NAME FIRST MIDDLE LAST Oscar Meyers				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Weber			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WW II 217-26-5372				17. INFORMANT 404 Nollmeyer Road Margaret O. Meyers--Balto., MD. 21220			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Thomas D. Smith</i>				TITLE (SPECIFY) M.D. Deputy Chief				DATE SIGNED 9/23/82			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. ADDRESS 111 Penn St. Balto., MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9/25/1982				23c. NAME OF CEMETERY OR CREMATORY Sacred Ht. Of Jesus			
23d. LOCATION CITY OR TOWN Dundalk				COUNTY Baltimore				STATE MD.			
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue Dundalk, MD. 21222						25a. DATE REC'D. BY REGISTRAR SEP 27 1982		25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR				ALBERT MILLER JR. DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 3 3 0 1			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
FIRST MIDDLE LAST Albert MILLER JR.				MONTH DAY YEAR 9-19-82				8:50 P.M.			
3. SEX MALE		4. RACE Caucasion		5. DATE OF BIRTH MONTH DAY YEAR 8 7 18		6. AGE (IN YEARS (LAST BIRTHDAY)) 64 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD				10. CITY OR TOWN OF DEATH BALTIMORE			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MECHANIC				12b. KIND OF BUSINESS OR INDUSTRY AIRCRAFT			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE md				13b. CITY OR TOWN BALTIMORE				13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST ALBERT MILLER SR.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIAN JAGO				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES - WW II			
16b. SOCIAL SECURITY NO. 217-14-3891				17. INFORMANT RUTH MILLER 1900 SUMMIT AVE.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic ca. colon</u> 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>1539</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/29</u> 19 <u>82</u> , to <u>9/19</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>9/19/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Anil Raiker MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 9/19/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANIL RAIKER MD				22e. ADDRESS Good Samaritan Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 9/22/82		23c. NAME OF CEMETERY OR CREMATORY PARKWOOD		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. BALTO. MD			
24. FUNERAL DIRECTOR J. C. ...				ADDRESS 1211 Chesapeake Ave.				25a. DATE REC'D. BY REGISTRAR SEP 20 1982		25b. REGISTRAR'S SIGNATURE John J. ...	

ALBERT HILLER JR.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified of this.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 3 3 0 8 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Anna M. Miller</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>Sept. 7 1982</i>		2b. HOUR <i>9 A</i>	
3. SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>12/25/1899</i>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <i>82 YRS.</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>BALTO., MD.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE CITY</i> MD.	
10. CITY OR TOWN OF DEATH <i>BALTIMORE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>JOHN L. DEATON MEDICAL CENTER</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>SELF EMPLOYED</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>FLORIST SHOP</i>	
13a. STATE <i>MARYLAND</i>				13b. COUNTY <i>BALTIMORE</i>		13c. CITY OR TOWN <i>CATONSVILLE</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>AUGUST STENZY</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ROSALIE ROTAJEZAK</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>				16b. SOCIAL SECURITY NO. <i>218.16.1433</i>		17. INFORMANT ADDRESS <i>RICHARD L. WILLE 544 RITA DR. ODENTON, MD.</i>	
18. CAUSE OF DEATH (Enter only one cause unless for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Osteogenic sarcoma - metastases</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pleural effusion assoc = "b"</i> 1709							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 3</i> , 19 <i>82</i> to <i>Sept 7</i> , 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>Sept 7</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death.							
22b. SIGNATURE <i>Julian W. Reed</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>9/7/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JULIAN W. REED</i>				22e. ADDRESS <i>6115 CHAS. ST. BALTO. MD. 21220</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>CREMATION</i>		23b. DATE <i>9/8/1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>GREEN MOUNT CREMATORY</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTO. MD.</i>	
24. FUNERAL DIRECTOR NAME <i>WALTER BROOKS BRADLEY, INC.</i>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>SEP 10 1982 John J. Canine</i>			

RECEIVED
JAN 10 1964

TO: Mr. J. Edgar Hoover
FROM: Mr. [illegible]
SUBJECT: [illegible]

[Faint, mostly illegible body text consisting of several paragraphs.]

Very truly yours,
[Signature]
[Illegible typed name]
[Illegible typed title]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 3 0 9
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) BOYCE ^{FIRST} Miller Jr. ^{MIDDLE} MILLER Jr. ^{LAST}		2a DATE OF DEATH MONTH DAY YEAR 9 6 82		2b HOUR 10³⁶ AM	
3 SEX M Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 5 28 1930		6 AGE (IN YEARS LAST BIRTHDAY) 52 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b CITIZEN OF WHAT COUNTRY? U. S.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10 CITY OR TOWN OF DEATH BALTIMORE		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSP		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER	
13a STATE MD		13b COUNTY ANNAPOIS		13c CITY OR TOWN ANNAPOIS	
14 FATHER'S NAME FIRST MIDDLE LAST Boyce E Miller Sr.		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Spivey			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 237-38-6612		17 INFORMANT Mrs Virginia H Miller ADDRESS 206 S. Cherry Grove Ave Annapolis, Md	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5198 IMMEDIATE CAUSE (a) Respiratory insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Under respiratory tract infection w/acute heart (c) Cystic Fibrosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21401			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Cystic Fibrosis					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from July 15 1982 , to Sept 6 1982 , that (I) (we) last saw the deceased alive on Sept 6 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Luis F. Gimenez		DEGREE MD		22c DATE SIGNED 9/6/82	
22d PHYSICIAN'S NAME (TYPE OR PRINT) LUIS F. GIMENEZ		22e ADDRESS John Hopkins Hospital Baltimore Md			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 9/8/82		23c NAME OF CEMETERY OR CREMATORY Greenmount	
23d LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		24 FUNERAL DIRECTOR NAME ADDRESS Leonard J Ruck Inc. Baltimore, Maryland			
25a DATE REC'D. BY REGISTRAR SEP 8 1982		REGISTRAR'S SIGNATURE John J. Conner			

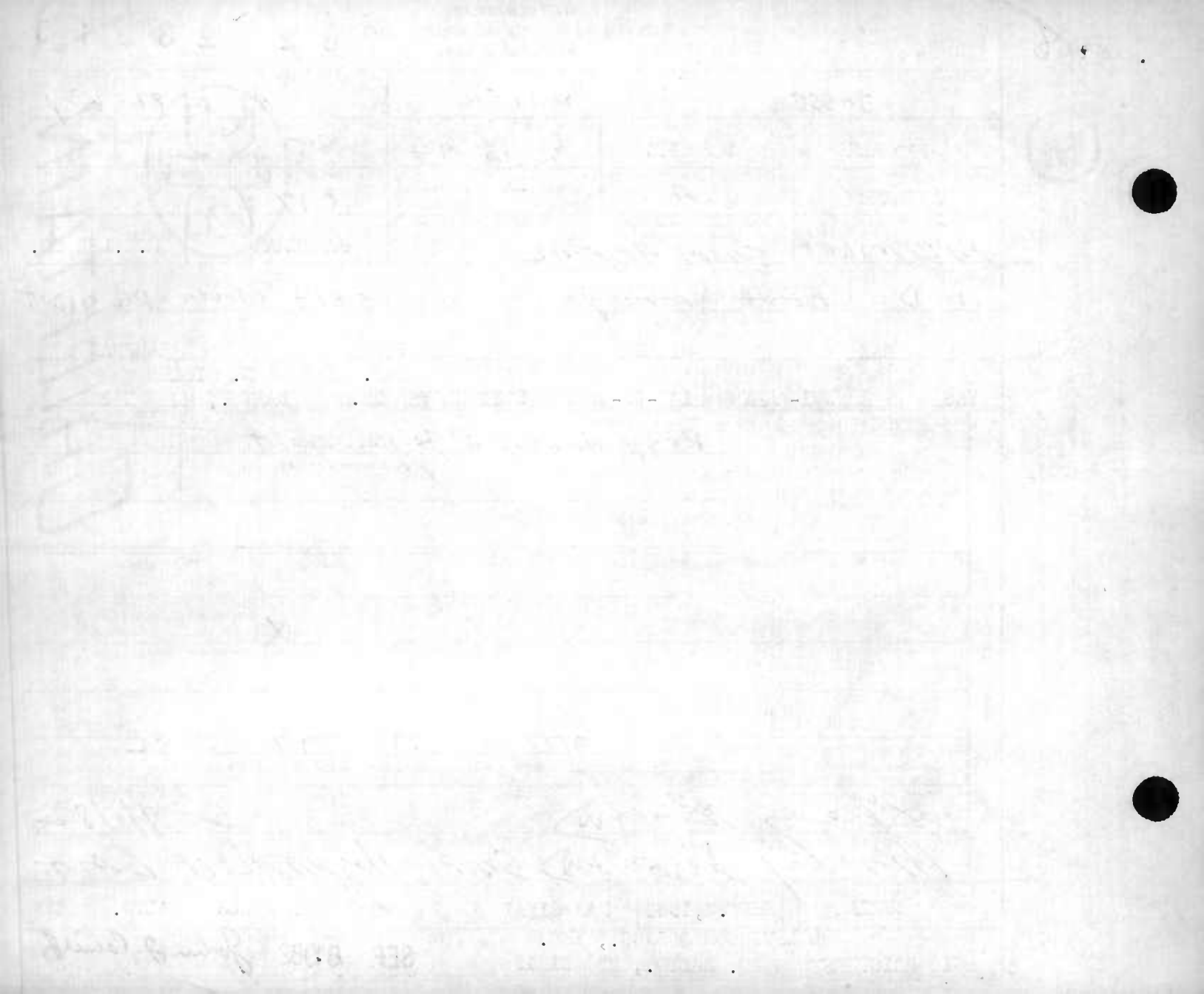
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Page 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 2 3 3 1 0			
1. FOR STATE REGISTRAR				20. DATE OF DEATH MONTH DAY YEAR			
I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2b. HOUR			
Jesse MILLER				09 01 82 6:30 PM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE		WHITE		3 13 97		85	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND		USA				CITY	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		SINAI HOSPITAL		SALESMAN		H.D. LEE CO.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MD		XXXXXX		BALTIMORE		YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
MAX MILLER				HENRIETTA KAUFMAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
YES		WWI-ARMY		142-03-0359A		MRS. MINERVA L. MILLER	
				5812 CLOVER RD.		BALTO., MD 21215	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) 4860 Resp Arrest 2° to recurrent pneumonia							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/1 1982, to 9/1 1982, that (I) (we) last saw the deceased alive on 9/1 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
HARRY ROSEN MD						9/1/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
HARRY ROSEN MD				SINAI HOSPITAL OF BALTO			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL		SEPT. 3, 1982		HAR SINAI		OWINGS MILLS BALTO. MD	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215				SEP 8 1982		John J. Conner	



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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 2 3 3 1 1			
1. DECEASED NAME (TYPE OR PRINT) FIRST M, MIDDLE Ruth, LAST Miller				2a. DATE OF DEATH MONTH 9 DAY 6 YEAR 82 2b. HOUR 23 ⁵ A.M.			
3. SEX F Female		4. RACE W White		5. DATE OF BIRTH MONTH 1 DAY 14 YEAR 1900		6. AGE (IN YEARS LAST BIRTHDAY) 82 82 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? WA U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Banking		12b. KIND OF BUSINESS OR INDUSTRY Retired	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY --		13c. CITY OR TOWN Baltimore		13d. STREET ADDRESS 1 E. University Pkwy. 21218	
14. FATHER'S NAME FIRST William MIDDLE H. LAST Miller				15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE G. LAST Greavar			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-03-7168 A		17. INFORMANT ADDRESS Mrs. Marylyn Estabrook Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) 2989 Sepsis							
DUE TO, OR AS A CONSEQUENCE OF (b) decubiti							
DUE TO, OR AS A CONSEQUENCE OF (c) bedridden & chronic dementia							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) pulmonary edema.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/5/82, 19 82, to 9-6, 19 82, that (I) (we) last saw the deceased alive on 9-6, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE John Bernstein, MD				DEGREE		22c. DATE SIGNED 9-6-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bernstein MD				22e. ADDRESS University Hospital, Baltimore			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/8/82		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Camatery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR Witzke P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228				25a. DATE REC'D. BY REGISTRAR SEP 8 1982		25b. REGISTRAR'S SIGNATURE John J. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

item 7a 4571 9/24/82 ph

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 3 1 2

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR September 4, 1982			1730 P M			
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY O. MILLER MIDDLE LAST			2b. DATE OF DEATH MONTH DAY YEAR			1730 P M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 26, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Long Green Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Poet		12b. KIND OF BUSINESS OR INDUSTRY Self-Emp.	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4202 Roland Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST Owings			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 159 18 1892		17. INFORMANT ADDRESS Arthur L. Dragger, Balto., MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Close V D								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/2 to 9/4, 1982, that (I) (we) last saw the deceased alive on 9/2, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (I) did not view the body after death.									
22b. SIGNATURE William G. Helfrich M.D.			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/7/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. William G. Helfrich, M.D.			22e. ADDRESS 5006 Roland Ave., Balto., MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 9/9/82		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., MD		
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212			25. DATE RECEIVED BY REGISTRAR SEP 3 1982						

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ring

OM : 01/06/2017

Green Mount

Henry W. Jenkins & Son Co.

1000 York Road, Suite 100, York, PA 17403

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 3 1 3

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		7 25 82		945 P.M.	
RUTH N. MILLER							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		Cauc.		MONTH DAY YEAR 6/29/10		72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Md.		U.S.				BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		UNION MEMORIAL HOSPITAL		Housewife		---	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.		---		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS			
FIRST MIDDLE LAST		FIRST MIDDLE LAST		440 Fawcett St.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
no		---		Son		---	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4100 Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/30</u> , 19 <u>82</u> , to <u>9/25</u> , 19 <u>82</u> , that (I) (we) <u>we</u> <u>saw</u> the deceased alive on <u>9/25</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Charles L. Diana</u> MD		22c. DATE SIGNED <u>9/25/82</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES L. DIANA		22e. ADDRESS UNION MEMORIAL HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		9/29/82		Mt. Zion		Freeland, Balto. Md.	
24. FUNERAL DIRECTOR NAME Paul E. Chenoweth 3rd. 3617 Chestnut Ave.				25a. DATE REC'D. BY REGISTRAR SEP 30 1982			
				REGISTRAR'S SIGNATURE <u>John J. Connelley</u>			

MEDICAL CERTIFICATION

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CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the Bureau after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

Item #250 per phone call w/Fun. Home		STATE OF MARYLAND		8 2 2 3 3 1 4	
FOR 10/1/82 rc		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		REG. NO.	
1- STATE REGISTRAR		CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) <i>VERA M. MILLER</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>9-25-82</i>		2b. HOUR <i>11:47 AM</i>	
3. SEX <i>F</i>	4. RACE <i>WHITE</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>DEC 15, 1913</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>68</i> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTO. CITY MD.</i>	
10. CITY OR TOWN OF DEATH <i>BALTO.</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>CHURCH HOSPITAL</i>		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <i>RETIRED</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>COOK</i>
13a. STATE <i>MD.</i>		13b. COUNTY	13c. CITY OR TOWN <i>BALTO.</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>916 S. HIGHLAND AVE.</i>
14. FATHER'S NAME FIRST MIDDLE LAST <i>JOHN BETCH ANNA SIMMOTT</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>215-05-7340</i>		17. INFORMANT ADDRESS <i>WM. J. MILLER SR. SAME 21224</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) <i>4289</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE OF PHYSICIAN <i>Walker Humphreys</i> DEGREE				22c. DATE SIGNATURE <i>9/27/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Walker Humphreys</i>				22e. ADDRESS <i>101 No Broadway - 21231</i>	
23a. BURIAL, CREMATION, REMOVAL (IF BY) <i>BURIAL</i>		23b. DATE <i>9-29-80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>SACRED HEART OF JESUS</i>	
23d. LOCATION (IF BY) <i>BALTO.</i>		23e. COUNTY <i>MD.</i>		23f. STATE	
24. FUNERAL DIRECTOR NAME <i>Hoffman-Skarda FH</i>		24b. ADDRESS <i>3218 Hudson St</i>		25a. DATE RECD. BY REGISTRAR <i>SEP 27 1982</i>	
25b. REGISTRAR'S SIGNATURE <i>Joan J. Carver</i>					

1. The first part of the report is a general introduction to the project. It describes the objectives of the study and the methods used to collect data. The introduction also mentions the importance of the research and the potential impact of the findings.

2. The second part of the report is a detailed description of the data collection process. It explains how the data was gathered, the instruments used, and the procedures followed to ensure the accuracy and reliability of the data.

3. The third part of the report is a presentation of the results. It includes a summary of the findings, a discussion of the results in relation to the research objectives, and a comparison of the findings with previous research in the field.

4. The fourth part of the report is a conclusion. It summarizes the main findings of the study and provides recommendations for future research. The conclusion also discusses the limitations of the study and the potential for further exploration of the research topic.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 3 3 1 5 REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST George R		LAST Minner		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
								9/10/82		6:51 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		White		12/7/23		58 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
WEST VIRGINIA		U.S.A.				Baltimore City MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		Baltimore City Hosps.						ENGINEER		RAILROAD	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
MARYLAND		BALTO.		DUNDALK				3507 LOUTH RD. 21222			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
GEORGE WILLIAM MINNER				JOHANNA SCHOLL							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
NO		235.28.4154		E. LOUISE MINNER (SAME AS 13e) (WIFE)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4149 cardiopulmonary arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (b) coronary artery disease											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) diabetes mellitus											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from 9/10 19 82, to 9/10 19 82, that (1) (we) lost saw the deceased alive on 9/10 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) did not view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
Mark C. Liu MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Mark C. Liu				Baltimore city Hospitals.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		9/14/1982		BEL AIR MEM. GARDENS		BEL AIR HARBOR MD.					
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222						SEP 15 1982		John J. Conner			

10/1/12

George

White

10/1/12

10/1/12

10/1/12

10/1/12

10/1/12

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10/1/12

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10/1/12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and a post-mortem examination required.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 3 1 6
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Rev. James A Minor			2a. DATE OF DEATH MONTH 9 DAY 12 YEAR 82			2b. HOUR 8:40 AM				
3. SEX male		4. RACE Black		5. DATE OF BIRTH MONTH 1 DAY 2 YEAR 12		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.				
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PROVIDENT Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST James MIDDLE A LAST Minor			15. MOTHER'S MAIDEN NAME FIRST Blanche MIDDLE Doric LAST Minor			13e. STREET ADDRESS 717 Drind Park Lake Dr			Apt 1307	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 217-05-8440			17. INFORMANT Evelyn Minor			ADDRESS 717 Drind Park Lake	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Congestive heart failure and DUE TO, OR AS A CONSEQUENCE OF probable acute myocardial Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) atherosclerosis, marked, of coronary arteries DUE TO, OR AS A CONSEQUENCE OF (c)									18b. ICHTHYOPATHIC RETHENING AND STRAIN	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pulmonary embolus, left lower lobe of lung and BPH										
19a. DATE OF OPERATION 9/9/82			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Benign prostatic Hypertrophy			19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 9/7/82 19 82 to 9/12 19 82 , that (I) (we) last saw the deceased alive on 9/12 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.										
22b. SIGNATURE Ray Bradie, Jr MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/14/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAY Bradie, Jr MD			22e. ADDRESS 844 N. CAREY ST. 21217							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burned			23b. DATE 9/16/82		23c. NAME OF CEMETERY OR CREMATORY Md. Veteran Cem			23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, Md		
24. FUNERAL DIRECTOR NAME Wm. C. Marsh ADDRESS F/H 1101 E. North Ave			25a. DATE REC'D. BY REGISTRAR SEP 15 1982			25b. REGISTRAR'S SIGNATURE John J. Conish				

10-12-82

NOTICE

FOR THE

OF THE

BOARD

OF THE

OF THE

OF THE

OF THE

OF THE

OF THE

10/18/82

11/15/82

12/15/82

1/15/83

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 3 1 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALICE MITCHELL			2a. DATE OF DEATH MONTH DAY YEAR September 3, 1982		2b. HOUR 10:20p	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9 13- 13		
6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS 68		IF UNDER 24 HRS. HOURS MIN. 10:20p		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY		MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 929 N. Washington St.				
14. FATHER'S NAME FIRST MIDDLE LAST Lallie Baker		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Johnson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-26-3085		17. INFORMANT ADDRESS Norwood Mitchell 929 N. Washington		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1990 IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) HEPATIC FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMATOSIS E LIVER METASTASES APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mi 1 month						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION none		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. LOCATION STREET CITY OR TOWN COUNTY STATE		21h. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 8/23 19 82 , to 9/3 19 82 , that (I) (we) last saw the deceased alive on 9/3 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE E Ruas MD		DEGREE		22c. DATE SIGNED 9/3/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. RUAS		22e. ADDRESS JOHNS HOPKINS HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/9/82		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cem		
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore		23e. LOCATION CITY OR TOWN COUNTY STATE Baltimore		23f. LOCATION CITY OR TOWN COUNTY STATE Baltimore		
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.		ADDRESS SEP 8 1982		25a. DATE REC'D. BY REGISTRAR SEP 8 1982		
25b. REGISTRAR'S SIGNATURE John J. [Signature]		25c. REGISTRAR'S SIGNATURE John J. [Signature]		25d. REGISTRAR'S SIGNATURE John J. [Signature]		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

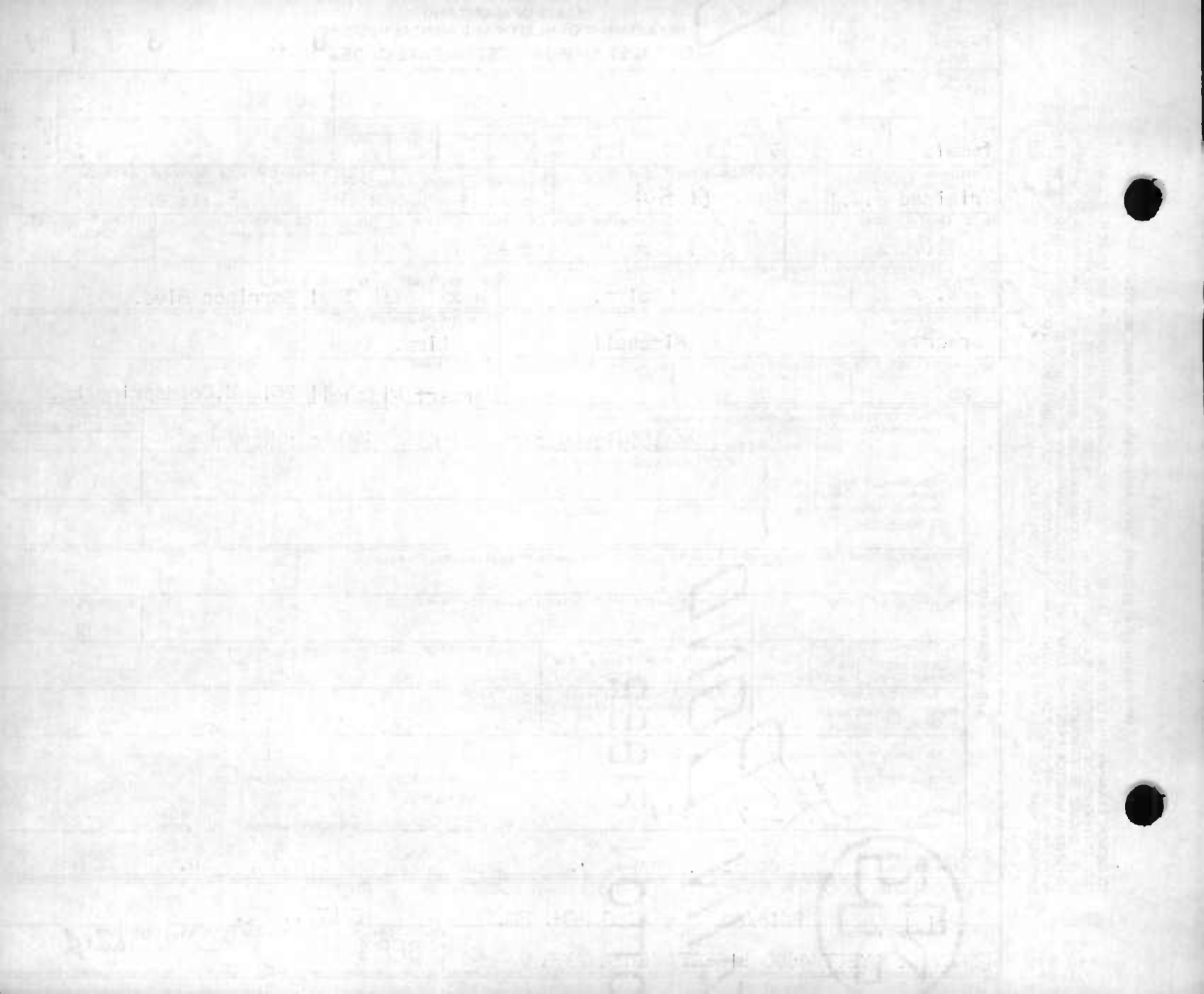
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 2 3 3 1 8			
1. FOR STATE REGISTRAR						2a. DATE OF DEATH MONTH DAY YEAR						2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Esther E. Mitchell						September 21, 1982						3:07 a.m.	
1. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 25, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retail Sales		12b. KIND OF BUSINESS OR INDUSTRY Dept. Store					
13a. STATE Maryland						13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 301 McMechen Street	
14. FATHER'S NAME FIRST MIDDLE LAST Nathaniel Mitchell						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Blair							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO.		17. INFORMANT Friend: ADDRESS Chrystie L. Larson, 1114 E. Fort Ave. 21230							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic shock 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Fracture of right HIP													
19a. DATE OF OPERATION September 20, 82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture of right HIP				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 9 17 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject fell at home									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 301 McMechen Street Baltimore City MD.		21g. CERTIFICATION APPROVED BY MEDICAL EXAMINER							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>September 17, 1982</u> to <u>September 21, 1982</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>September 21, 1982</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death.													
22b. SIGNATURE <u>Jim-Jer Hwu M.D.</u> DEGREE						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/21/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jim-Jer Hwu, M.D.						22e. ADDRESS c/o Maryland General Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/24/82		23c. NAME OF CEMETERY OR CREMATORY Arbon Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Blossburg, Tioga Co., PA							
24. FUNERAL DIRECTOR NAME ADDRESS STEWART & MOWEN CO., 108 W. North Ave. 21201						25a. DATE REC'D. BY REGISTRAR SEP 23 1982		25b. REGISTRAR'S SIGNATURE <u>Sam J. Conner</u>					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 2 2 3 3 1 9	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Myrtle B. Mitchell										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 9 9 1982	
3. SEX female		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 7 29 57		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 25 YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 10 1982		2b. HOUR 10:14 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Trinidad B.W.I.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3401 Garrison Blvd -Roof				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.				13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3401 Garrison Blvd.	
14. FATHER'S NAME FIRST MIDDLE LAST Herbert Mitchell						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lima					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No						16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Herbert Mitchell 2616 W.Coldspring La.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple gunshot wounds</u> Weapon: <u>handgun</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR est 9/9 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) found shot					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roof top		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3401 Garrison Blvd, Baltimore MD					
22a. I certify that I took charge of the remains described above, held on death resulted from: <u>Natural causes</u> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <u>H R Guard</u>				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER		DATE SIGNED 9/10/82	
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, MD.				ADDRESS 111 Penn Street, Balto., MD 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9/15/82		23c. NAME OF CEMETERY OR CREMATORY KING MEM. PK.				23d. LOCATION CITY OR TOWN COUNTY STATE BALTO., MD.	
24. FUNERAL DIRECTOR NAME LEROY O. DYETT 4600 LIBERTY HGTS. AVE.				25a. DATE REC'D. BY REGISTRAR 9/15/82				REGISTRAR'S SIGNATURE <u>John J. Caber</u>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM RM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Deborah Mae Moeller			2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 9 19 82			2b. HOUR 2:25 a.m.		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10 1 49	6. AGE (IN YEARS LAST BIRTHDAY) 32 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 9 19 82		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 326 S. Fulton Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ---		12b. KIND OF BUSINESS OR INDUSTRY ---
13a. STATE Maryland		13b. COUNTY	13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 326 S. Fulton Avenue 21223		
14. FATHER'S NAME FIRST MIDDLE LAST Donald H. Moeller, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Phyllis L. Powell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 215-48-2718		17. INFORMANT ADDRESS 21223 Phyllis L. Nearhood 326 S. Fulton Avenue		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Lung Disease 5188 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE Dennis F. Smyth, M.D.		TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 9-19-82		
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn Street						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/22/82		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.				ADDRESS 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR SEP 20 1982		25b. REGISTRAR'S SIGNATURE John J. Conner

1903 BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 3 2 1
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) McArthur Montgomery			2a. DATE OF DEATH MONTH DAY YEAR 9 28 82			2b. HOUR 1:00 A.M.					
3. SEX male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 6 3 49		6. AGE (IN YEARS LAST BIRTHDAY) 33 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 33			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1809 N. Monroe Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1809 N. Monroe St. 1st Fl		
14. FATHER'S NAME FIRST MIDDLE LAST Dave Montgomery				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Cooper							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 250-90-6175		17. INFORMANT ADDRESS Lou Rena Montgomery 1809 Monroe St					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain metastases. 1700 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Osteogenic Sarcoma of left maxillary sinus (1980). DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Decubitus ulcers.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from August 10, 19 82 to Sept 28, 19 82 , that (I) (we) last saw the deceased alive on Sept 23, 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.											
22b. SIGNATURE George Taler M.D.						DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/30/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Taler, M.D.						22e. ADDRESS 600 Light St. Balt. Md. 21210					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10/2/82		23c. NAME OF CEMETERY OR CREMATORY Fellowship Bapt		23d. LOCATION CITY OR TOWN COUNTY STATE Manning S.C.				
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. north						25a. DATE REC'D. BY REGISTRAR OCT 1 1982		25b. REGISTRAR'S SIGNATURE John J. Connel			



State your name of left investigation (Name)
State investigation (Name)

Investigation (Name)

State your name of left investigation (Name)

State your name of left investigation (Name)

Investigation (Name)

76

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner will be contacted for an autopsy.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 3 3 2 2 REG. NO.							
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)						2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
		Earl J. Moody						9		18		82		M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.							
Male		Black		5 18 24		58 YRS		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
New Jersey		USA				Baltimore City, MD											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		1506 Penna Avenue Apt. A7															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1506 Penna Ave. Apt. A7									
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME													
Earl J. Moody Sr.				Blanche													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS									
Yes				216-28-6197				Louise Moody 1506 Penna Ave Apt. A7									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY:																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u>																	
1419																	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>RESPIRATORY INSUFFICIENCY</u>																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>FAR ADVANCED CANCER OF TONGUE</u>																	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>MALNUTRITION DUE TO MALIGNANCY; MARKED WASTING</u>																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)									
				HOUR A.M. MONTH DAY YEAR P.M. 19													
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>								STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY</u> 19 <u>82</u> to <u>SEP</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>JULY</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE				DEGREE				22c. DATE SIGNED									
<u>TCHERMEKIAN, NERSES</u>								ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS													
				UNIV. OF MD CANCER CENT.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
BURIAL				9/23/82				Md. Veteran Cem				Crownsville Md.					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
NAME ADDRESS				SEP 21 1982				<u>John J. Carver</u>									
Wm. C. March F/H 1101 E. North Ave.																	

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST PAULINE		MIDDLE MOORE		LAST MOORE		2a. DATE OF DEATH MONTH DAY YEAR 09-02-82 145	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 06-14-1903		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7b. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINDALE HEBREW HOME				12a. USUAL OCCUPATION (TYPE OF WORK AND MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2500 W. BELVEDERE AVE. 21215	
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS VOLKIN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE REBECCA GREENBERG					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-32-8168-D		17. INFORMANT MRS. BETTY AXELROD ADDRESS 3900 FORDS LA., APT. 103 #21215					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ischemic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk YEARS.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>pneumonia</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>2-18</u> , 19 <u>82</u> , to <u>9-2</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>9-2</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9-2-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>B. W. Winkler</u>				22e. ADDRESS <u>Levinale Heb. Genative Ctr. Balto 21215</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE SEPT. 3, 1982		23c. NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MARYLAND			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR SEP 8 1982		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 2 2 3 3 2 4 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM P. MOON					2a. DATE OF DEATH MONTH DAY YEAR 09-29-82			2b. HOUR MIN. 10:40 P.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 08-08-14		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.			
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NO. CH. GEN. HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FIREMAN		12b. KIND OF BUSINESS OR INDUSTRY RETIRED	
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 321 W. 27 TH ST.	
14. FATHER'S NAME FIRST MIDDLE LAST P.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST P.		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					
		16b. SOCIAL SECURITY NO. 219-01-0652		17. INFORMANT ADDRESS WIFE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a). MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) ANOXIC/ISCHEMIC ENCEPHALOPATHY									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 09-17-82 to 09-28-82, that (I) (we) lost saw the deceased alive on 09-28-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Cesar Gamboa MD.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9-28-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CESAR GAMBOA MD.				22e. ADDRESS 900 N. CHARLES GEN HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/1/82		23c. NAME OF CEMETERY OR CREMATORY REISTERSTON METH.		23d. LOCATION CITY OR TOWN COUNTY STATE REISTERSTON MARYLAND			
24. FUNERAL DIRECTOR NAME Paul E. Chonowicki				ADDRESS 3617 Chestnut Ave		25a. DATE REC'D. BY REGISTRAR OCT 4 1982		25b. REGISTRAR'S SIGNATURE John J. Conner	

12

DATE	10-10-1944	TIME	10:00 AM
NAME	JOHN J. BARRY	AGE	34
SEX	M	HT	5' 8"
WGT	170	HAIR	Brown
EYES	Blue	SKIN	Fair
EDUCATION	High School	RELIGION	Catholic
OCCUPATION	Police Officer	RESIDENCE	123 Main St, Boston
REMARKS	Interviewed by Special Agent Smith. Subject is a reliable source of information.		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician who completely filled in by the hospital or attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed without 23 in the office of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately by telephone at 330-1073.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 2 3 3 2 5			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST ELsie MOORE		2a. DATE OF DEATH MONTH DAY YEAR SEPT. 30, 1982				2b. HOUR 12:01 A M			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 30 05		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.				IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.							
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1321 N. Eden Street 21213					
14. FATHER'S NAME FIRST MIDDLE LAST Quentin Baker				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora Mitchell									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 215-22-1071		17. INFORMANT ADDRESS Fannie Simpson 261 Colvin St. 21202									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypotension 4349 DUE TO, OR AS A CONSEQUENCE OF (b) cerebellar infarct Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mn. 1 wk.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Long history hypertension, poorly controlled													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE-FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (his hospital) attended the deceased from 9/23, 1982, to 9/30, 1982, that (I) (we) lost saw the deceased alive on 9/30, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE M. D.				DEGREE				22c. DATES SIGNED 9/30/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Nelson				22e. ADDRESS Johns Hopkins Hosp									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/5/82		23c. NAME OF CEMETERY OR CREMATORY Mount Calvary Cem				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.					
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Avenue				25a. DATE REC'D. BY REGISTRAR OCT 1 1982				25b. REGISTRAR'S SIGNATURE Jan J. Canish					

12:00

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the body is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 3 3 2 6 REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) George C. Moore			2a. DATE OF DEATH MONTH DAY YEAR Sept 5, 1982			2b. HOUR 1:55 PM		
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 4 29 48		6. AGE (IN YEARS LAST BIRTHDAY) 34 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4104 Boarman Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST Wyatt Moore				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evelyn Martin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-52-8578		17. INFORMANT Evelyn Lofton				ADDRESS Rt. 2, Box 536			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4860 IMMEDIATE CAUSE (a) HIGH OUTPUT CARDIAC FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA AND DUE TO, OR AS A CONSEQUENCE OF (c) ALCOHOLIC LIVER DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (a) this hospital attended the deceased from SEPT 4, 19 82, to SEPT 5, 19 82, that (b) (we) lost saw the deceased alive on SEPT 5, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Irving A. Cohen				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED Sept 5, 1982			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) IRVING A. COHEN				22e. ADDRESS 2600 LIBERTY HTS							
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 9/10/82		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.		23d. LOCATION CITY OR TOWN Arbutus		COUNTY STATE Md.			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Avenue				25a. DATE REC'D. BY REGISTRAR SEP 8 1982		25b. REGISTRAR'S SIGNATURE John J. Connel					

37

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 3 3 2 7			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN CONRAD MOORE				2a. DATE OF DEATH MONTH DAY YEAR Sept 10 82		2b. HOUR 3:30A M	
3 SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR APR. 18 1895		6. AGE (IN YEARS (LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS. 87 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? US of A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC LOCH RAVEN BLVD. BALTO. MD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
13a. STATE MARYLAND		13b. COUNTY AA Co.		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 717 FAIRWAY DR. 21401		14. FAIRFAX NAME FIRST MIDDLE LAST JOHN W. MOORE		15. MOTHER'S MAIDEN NAME KATHARINE KNESS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW I 718 18 8341		17. INFORMANT ADDRESS MR. JAMES K. MIZEROVSKY 717 FAIRWAY DR.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest 4289 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) heart failure							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CONTRIBUTING TO DEATH							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (if this hospital) attended the deceased from September 5, 19 82 to Spt. 10, 19 82 , that xx (we) lost saw the deceased alive on Sept. 10, 19 82 , and that in xx (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.							
22b. SIGNATURE Charles E. Sheehan M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles E. Sheehan M.D.				22e. ADDRESS 3900 Loch Raven Blvd. Balto. Md. 21218			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/15/82		23c. NAME OF CEMETERY OR CREMATORY CROWNSVILLE VET. CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE CROWNSVILLE (AA Co.) MD.	
24. FUNERAL DIRECTOR NAME LEWIS T. GWYNN 4517 PARK HEIGHTS AVENUE				25a. DATE REC'D. BY REGISTRAR SEP 14 1982		25b. REGISTRAR'S SIGNATURE John J. Canine	

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CONFIDENTIAL (U.S. GOVERNMENT PRINTING OFFICE: 1964)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 3 3 2 8	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Elizabeth A. Moran			2a. DATE OF DEATH MONTH DAY YEAR Sept. 6, 1982		2b. HOUR 2:30 PM
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR May 2, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Long Green Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Towson	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Stephen F. Clark			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice McCadden		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 216-46-6547		17. INFORMANT ADDRESS N. Clark Moran, 8011 Strauff Rd. Bal. Md. 21204	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIC SHOCK 5990 DUE TO, OR AS A CONSEQUENCE OF (b) URINARY TRACT INFECTION DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 Weeks 24 Hours					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 1980 to 6 SEPT 1982, that (I) saw the deceased alive on 6 SEPT 1982, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Dr. J. Dixon Hills		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7 Sept 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. J. Dixon Hills		22e. ADDRESS 3501 St. Paul St.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 9, 1982		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Md.					
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home 6500 York Road Bal. Md.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 15 1982 John J. Carver			

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19-110-5011

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 2 2 3 3 2 9 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) ALBERT W. MORGAN						2a. DATE OF DEATH MONTH DAY YEAR 9 29 82		2b. HOUR 4:15 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 4, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman		12b. KIND OF BUSINESS OR INDUSTRY Warehouse	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1303 Walters Avenue 21239	
14. FATHER'S NAME FIRST MIDDLE LAST Albert T. Morgan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nannie Wehrhahn					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 215 07 9763		17. INFORMANT ADDRESS Mrs. Viola E. Morgan Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest.</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Massive myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>9/17</u> , 19 <u>82</u> , to <u>9/29</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>9/29</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Adel S. El-Hennawy</u>				22c. DATE SIGNED 9/29/82				22d. PHYSICIAN'S NAME (TYPE OR PRINT) ADEL S. EL-HENNAWY	
22e. ADDRESS GSH				22f. DATE SIGNED 9/29/82					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/2/82		23c. NAME OF CEMETERY OR CREMATORY Moreland		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Co., MD			
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto., MD 21212						25a. DATE REC'D. BY REGISTRAR OCT 1 - 1982		25b. REGISTRAR'S SIGNATURE John J. Con...	

ENCLOSURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-pen pages 1 and 2 and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified about it.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James Irving Morris			2a. DATE OF DEATH MONTH DAY YEAR 09 13 82			2b. HOUR 9:30 am			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 6-18-1916		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steelworker-Retired		12b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. CITY OR TOWN Balto.		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 2002 Denbury Dr.-21222		
14. FATHER'S NAME FIRST MIDDLE LAST Lorus Morris				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Virginia Shiflett					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes Navy WWII				16b. SOCIAL SECURITY NO. 218-18-1611		17. INFORMANT Charles H. Morris-3400 Pearl Dr.-Suitland, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Fulminant Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Lung Cancer								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minutes 48 hrs. 2-3 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION 7/9/82			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Lung Cancer			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/6, 19 82, to 9/13, 19 82, that (I) (we) last saw the deceased alive on 9/13, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert Udelsman MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/13/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Udelsman MD						22e. ADDRESS Baltimore City Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-15-82		23c. NAME OF CEMETERY OR CREMATORY Prize Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Boonesville Va.		
24. FUNERAL DIRECTOR NAME ADDRESS John C. Miller Inc-6415 Belair Rd.-21206						25a. DATE REGD. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 14 1982 John J. Canine			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 3 3 3 1 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Evelyn E. Mosley				2a. DATE OF DEATH MONTH DAY YEAR 9 16 82				2b. HOUR 9 05 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 9, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2827 Hudson St 21224			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore					
14. FATHER'S NAME FIRST MIDDLE LAST Ethington B Merritt				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna S Pohler					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 229-750		17. INFORMANT Edward B Mosley				ADDRESS Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2500 Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Arterio Sclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. — 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) —					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Sept 12 19 82 , to Sept 16 19 82 , that (I) (we) last saw the deceased alive on Sept 16 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Harry S. [Signature]				DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/16/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Union Memorial Hospital				22e. ADDRESS Union Memorial Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/20/82		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR (BY REGISTRAR'S SIGNATURE) SEP 17 1982 [Signature]					

11

History

Examination

Physical examination

Union Memorial Hospital

Examination

Union Memorial Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Department of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner should be notified and a medical certificate completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 3 3 2 REG. NO.							
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
1. DECEASED NAME FIRST MIDDLE LAST Gabriel Herman Muller				9/25/82				8:50 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11-21-12		6. AGE (IN YEARS LAST BIRTHDAY) 69		IF UNDER 1 YEAR MONTHS DAYS YRS.		IF UNDER 74 HRS. HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John Hopkins Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Salesman		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8105 Bon Air Rd. 21234			
14. FATHER'S NAME FIRST MIDDLE LAST Gabriel Muller				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Bertling							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 217-09-7842A		17. INFORMANT ADDRESS Isabelle Muller, 8105 Bon Air Rd. 21234					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 3989 IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) RENAL FAILURE										WEEKS	
DUE TO, OR AS A CONSEQUENCE OF (c) HEART CONGESTIVE FAILURE										YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a Rheumatic heart disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 17		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from SEPT. 17 , 19 82 , to SEPT. 25 , 19 82 , that (I) (we) lost saw the deceased alive on SEPT. 25 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Elizabeth Streeten MD				DEGREE MD				22c. DATE SIGNED 9/25/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Elizabeth Streeten				22e. ADDRESS Johns Hopkins Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-29-82		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.					
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc., 5305 Harford Rd. 21214				25a. DATE REC'D. BY REGISTRAR SEP 27 1982		25b. REGISTRAR'S SIGNATURE John J. Canineh					

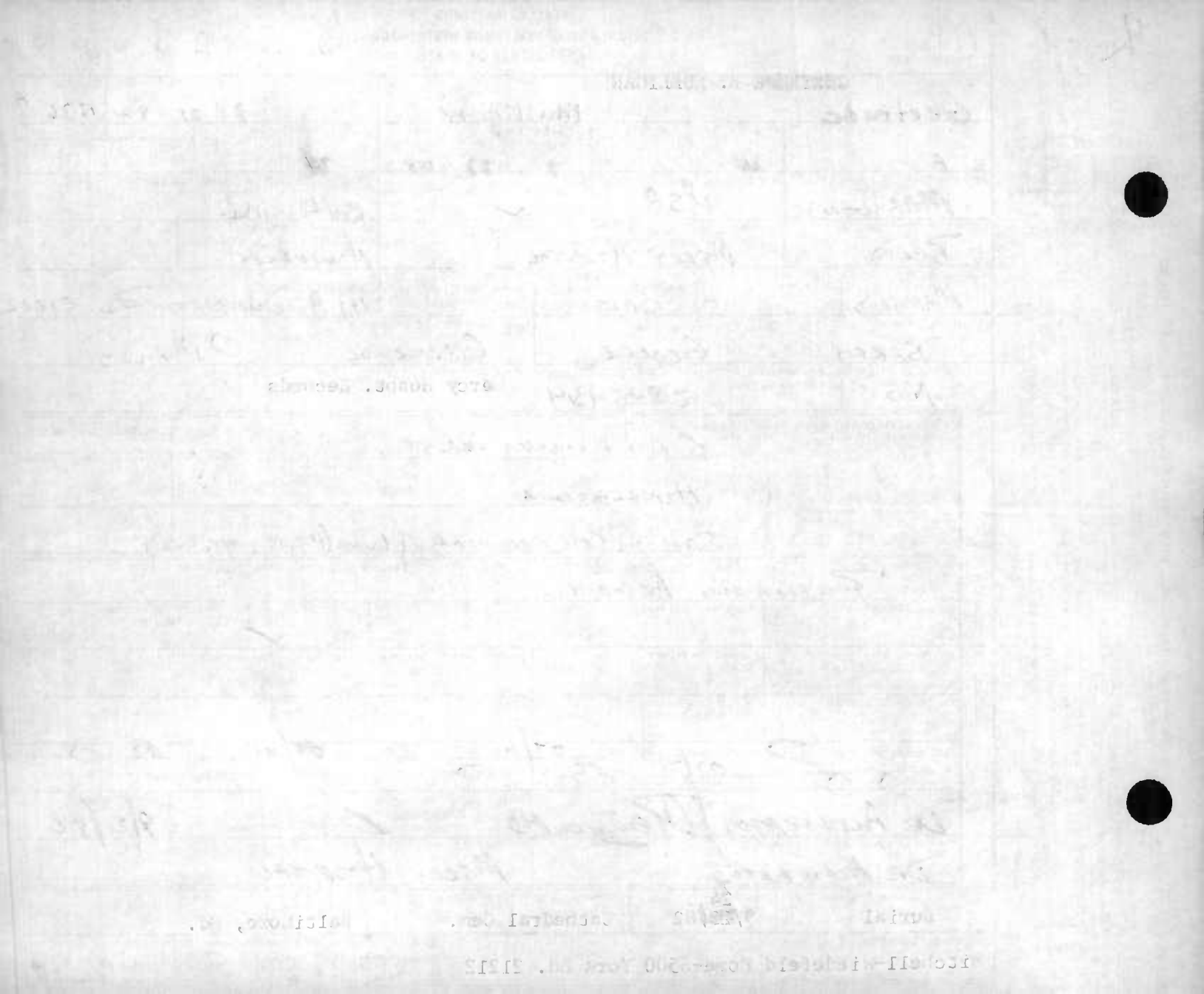
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 2 2 3 3 3 3
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Gertrude B. MULLIGAN		LAST Mulligan		2a. DATE OF DEATH MONTH DAY YEAR 9 21 82		2b. HOUR 1:36 ^A	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 7 27 08		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. Md. MD.	
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST BARRY MIDDLE GEORGE LAST GEORGE		15. MOTHER'S MAIDEN NAME FIRST GERTRUDE MIDDLE O'MAILEY LAST O'MAILEY		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-05-1314	
17. INFORMANT ADDRESS Mercy Hospt. Records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST 1629 DUE TO, OR AS A CONSEQUENCE OF (b) HYPERCALCEMIA DUE TO, OR AS A CONSEQUENCE OF (c) SQUAMOUS CELL CARCINOMA of LUNG (RIGHT UPPER LOBE)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) RHEUMATOID ARTHRITIS							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) Dr. Alexizatos attended the deceased from 07/01 , 19 82 , to 09/21 , 19 82 , that (I) (we) last saw the deceased alive on 09/21 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did (did not) view the body after death.							
22b. SIGNATURE DR. ALEXIZATOS		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/21/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ALEXIZATOS		22e. ADDRESS Mercy Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/24/82		23c. NAME OF CEMETERY OR CREMATORY Cathedral Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home-6500 York Rd. 21212 ADDRESS				25a. DATE REC'D. BY REGISTRAR SEP 27 1982		25b. REGISTRAR'S SIGNATURE James J. Connel	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 3 3 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Grace Belle Mullinix			2a. DATE OF DEATH MONTH DAY YEAR September 20, 1982			2b. HOUR 4:25 P M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov 7, 1987		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Howard Co., Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2211 W. Rogers Ave.,	
14. FATHER'S NAME late Charles E. Mullinix					15. MOTHER'S MAIDEN NAME late Katie Burdette					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218 14 1445		17. INFORMANT John Murray 1311 McCurley ST Catonsville					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Failure 0389 DUE TO, OR AS A CONSEQUENCE OF (b) Possible Sepsis Secondary To Decubitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) Possible Peritonitis										
19a. DATE OF OPERATION 9/3/82			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Feeding Gastrostomy			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from July 30, 1982, to Sept. 20, 1982, that (1) (we) lost saw the deceased alive on Sept. 20, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Edmond McDonnell, Jr., M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/20/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edmond McDonnell, Jr., M.D.						22e. ADDRESS c/o Maryland General Hospital				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept 23, 1982		23c. NAME OF CEMETERY OR CREMATORY Howard Chapek		23d. LOCATION CITY OR TOWN COUNTY STATE Howard Maryland			
24. FUNERAL DIRECTOR NAME Harry H Witzke 4112 Columbia Rd Ellicott City						25a. RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 23 1982				

also Maryland General Hospital

Howard County, Md.

Sept 20

July 22

Feeding Gastroscopy

Regalia Peritonitis

Respiratory System Secondary to Dehydration

Cardiovascular Failure

John Henry, 1711 McKinley St. Cincinnati, Ohio 45219

Lave Marie Bunnell

Lave Marie Bunnell

Wilshire

x

2211 N. Hogan Ave.

Howard General Hospital

Howard

Howard Co. Md.

U.S.A.

x

Baltimore City

White

Nov. 1, 1981

on

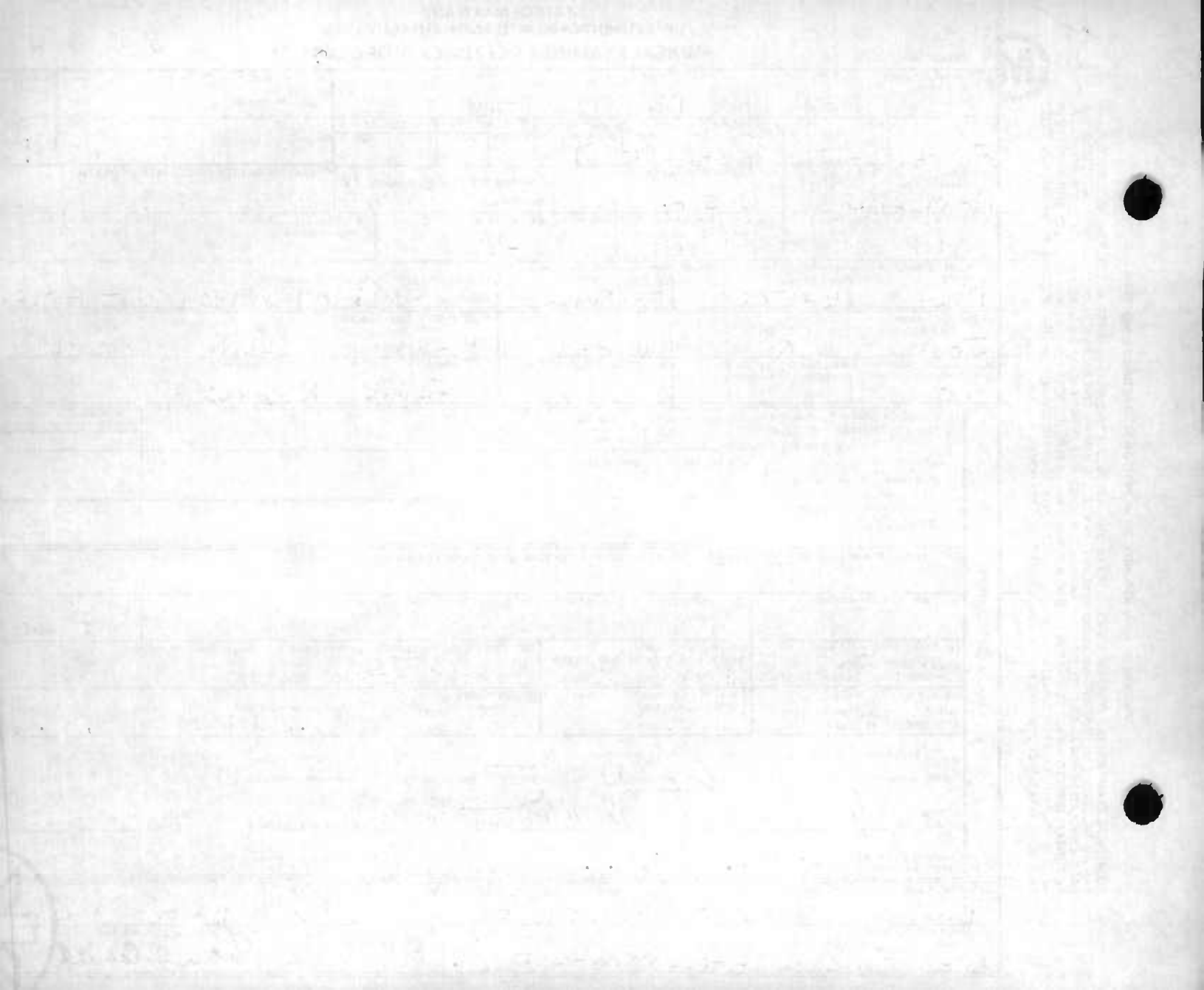
White

William

September 20, 1982

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 2 3 3 3 5	
1. DECEASED NAME (TYPE OR PRINT) Jean M. Murphy						2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 9 18 1982		2b. HOUR M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MARCH 24 1965 17 YRS.		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD 9 18 1982	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital - STU				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. CITY OR TOWN BALTO. 13c. CITY OR TOWN PARKVILLE						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2909 CONROY COURT APT. A			
14. FATHER'S NAME FIRST MIDDLE LAST JAMES R. MURPHY						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY Ellen CORNELL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS FAMILY RECORDS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: Multiple Injuries 8147 IMMEDIATE CAUSE (a): DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b): DUE TO, OR AS A CONSEQUENCE OF (c):										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR 11:00 P.M. MONTH DAY YEAR 9 17 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) pedestrian struck by auto					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Ridgley & Joppa Rds., Baltimore County, Md.					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 9-18-82			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9-21-1982		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION CITY OR TOWN COUNTY STATE 5533X BALTO. MD.			
24. FUNERAL DIRECTOR NAME ADDRESS EVANS FUNERAL CHAPEL 8800 HARFORD				25a. DATE REC'D. BY REGISTRAR SEP 20 1982		25b. REGISTRAR'S SIGNATURE <i>John J. Connelley</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8 2 2 3 3 3 6 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM P. MURPHY					2a. DATE OF DEATH MONTH DAY YEAR SEPT. 6, 1982					2b. HOUR 5:12 a	
1. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 17 1903			6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Essex 21221		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber		12b. KIND OF BUSINESS OR INDUSTRY Ship Yard		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. CITY OR TOWN Baltimore 13c. CITY OR TOWN Essex 21221					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 50 B Westway North				
14. FATHER'S NAME FIRST MIDDLE LAST Timothy S. Murphy					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Ward						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS 9A Westway South Evelyn Murphy, Wife Balto., Md. 21221							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF LUNG WITH LIVER METASTASIS DUE TO, OR AS A CONSEQUENCE OF (c) RENAL FAILURE										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8-05 to 9-6, 1982, that (I) (we) lost saw the deceased alive on 9-6, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE MUKESH LUHAR					DEGREE			22c. DATE SIGNED 9/6/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MUKESH LUHAR					22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTO. MD. 21231						
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 9/8/82		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Gardens			23d. LOCATION CITY OR TOWN BALTIMORE COUNTY STATE			
24. FUNERAL DIRECTOR NAME ADDRESS Prudzinski Funeral Home PA 1407 Old Eastern Ave.					25a. DATE REC'D. BY REGISTRAR IN REGISTRAR'S SIGNATURE SEP 7 1982 John J. Conner						

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 2 3 3 3 7			
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) Michael Thomas Murrill										DATE KNOWN OF DEATH ESTIMATED		MONTH DAY YEAR	
1. SEX M 4. RACE Negro 5. DATE OF BIRTH 4-20-63 6. AGE (IN YEARS) 19 YRS. 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.										9 30 1982		7:30 PM	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stewardant		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md. 13b. COUNTY Dor. 13c. CITY OR TOWN Cambridge										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 605 Cross St. Camb., Md.			
14. FATHER'S NAME FIRST MIDDLE LAST Gerald E. Murrill										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Watford			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No (IF YES, GIVE WAR OR DATES)										16b. SOCIAL SECURITY NO. 217-90-3396		17. INFORMANT (MOTHER) Mary E. Woolford 605 Cross St. Camb., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9654 IMMEDIATE CAUSE (a) Gunshot wound of head Weapon: Unspecified DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:26 P 9/20 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) front of 709 Pine Street, Cambridge, Dorchester County, MD										21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>										TITLE (SPECIFY) M.D. Assistant		DATE SIGNED 10/1/82	
ACTUAL SIGNATURE H.R. Guard										M.D. Assistant		MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.										ADDRESS 111 Penn Street, Balto., MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 10-6-82		23c. NAME OF CEMETERY OR CREMATORY Hughes Chapel	
23d. LOCATION CITY OR TOWN COUNTY STATE										23e. DATE REC'D. BY REGISTRAR OCT 8 1982		23f. REGISTRAR'S SIGNATURE John J. Canfield	
24. FUNERAL DIRECTOR NAME L.H. Boardley 812 Hubbard St. Camb., Md.										24a. DATE REC'D. BY REGISTRAR OCT 8 1982		24b. REGISTRAR'S SIGNATURE John J. Canfield	

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Wetzel 11-20-63 19

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217-3335

Wetzel 11-20-63

Wetzel 11-20-63

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

0000 BP
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 3 3 3 8	
1. DECEASED NAME (TYPE OR PRINT) Tera Bernice Myers						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 9 DAY 8 YEAR 19 82		2b. HOUR 5:41 P.M.			
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH 3 DAY 19 YEAR 79	6. AGE (IN YEARS LAST BIRTHDAY) 3 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD MONTH 9 DAY 8 YEAR 19 82		2d. HOUR 5:41 P.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City. MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland 13b. CITY Baltimore 13c. CITY OR TOWN White Marsh						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 11445 Philadelphia Road			
14. FATHER'S NAME FIRST Thomas MIDDLE D. LAST Smith				15. MOTHER'S MAIDEN NAME FIRST Marlene MIDDLE Myers LAST Myers							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Marlene Myers 11445 Philadelphia Road						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Blunt trauma to abdomen 9190 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR 4:25 P.M. MONTH 9 DAY 8 YEAR 19 82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject struck by backhoe						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) yard		21f. LOCATION STREET 11145 Philadelphia Rd. CITY OR TOWN White Marsh, COUNTY Balto., STATE Md.						
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Thomas D. Smith			TITLE (SPECIFY) Deputy Chief				DATE SIGNED 9/9/82				
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.			ADDRESS 111 Penn St.				BALTO., MD.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/11/82		23c. NAME OF CEMETERY OR CREMATORY Holly Hills Cemetery		23d. LOCATION CITY OR TOWN Baltimore COUNTY Maryland STATE Md.				
24. FUNERAL DIRECTOR NAME Wm C. Brown Comm. F/H 1206-08 W. North Ave. ADDRESS 1206-08 W. North Ave.					25a. DATE REC'D. BY REGISTRAR SEP 14 1982		25b. REGISTRAR'S SIGNATURE James J. Connel				

RECEIVED

NOV 10 1954



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 3 3 9
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIE (NMI) NANCE		2a. DATE OF DEATH MONTH DAY YEAR 09 / 27 / 82		2b. HOUR 6:40 AM	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 12 23 33		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 49 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MARYLAND HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NOT KNOWN		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. CITY OR TOWN BALTIMORE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 2115 MURA STREET 21213	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Nance		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Nance					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT ADDRESS Minola Nance 2115 Mura St. 21213			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 4860 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 DAYS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) LARYNGEAL CANCER (?1978/?1980) WITH POSSIBLE RECENT RECURRENCE							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 18, 19 82, to SEPTEMBER 27, 19 82, that (I) (we) lost saw the deceased alive on SEPTEMBER 27, 19 82, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death.							
22b. SIGNATURE Darryl Bruce Kurland				DEGREE MD		22c. DATE SIGNED 9/27/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DARRYL BRUCE KURLAND				22e. ADDRESS UNIVERSITY OF MD. HOSPITAL - FAM. PRACTICE DEPT.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/1/82		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North Avenue				25a. DATE REC'D. BY REGISTRAR SEP 28 1982		25b. REGISTRAR'S SIGNATURE John J. Ganiel	

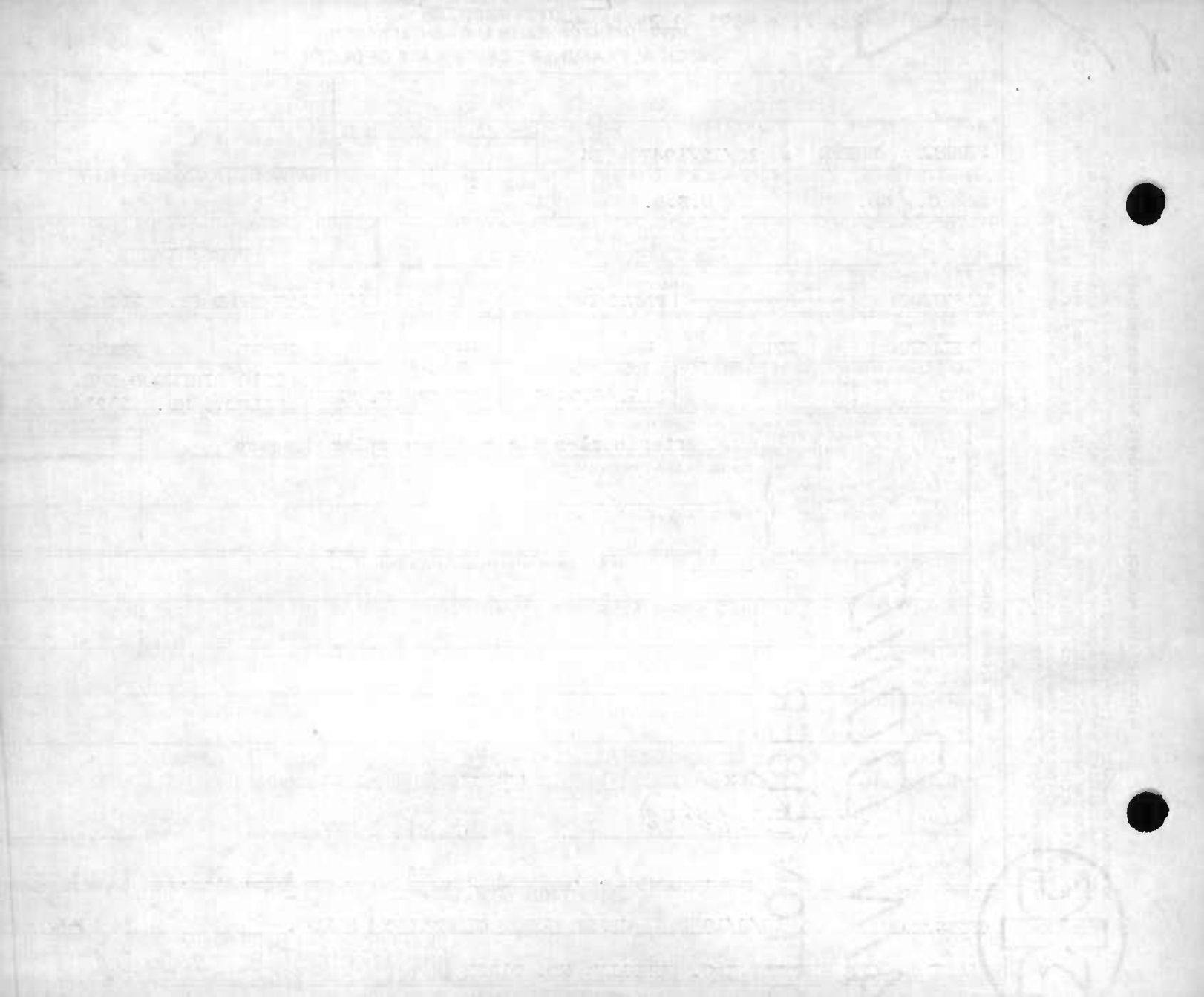
Items #18a-22a Film G573 11/24/82 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
Patricia Re Napfel								9		26		19		82					
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
FEMALE	WHITE	10/12/1947		34 YRS.						9		26		19		82		1:47	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH									
BALTO., MD.		U.S.A.		WIDOWED		NEVER MARRIED		DIVORCED		Baltimore City									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Baltimore		514 Cathedral Street		HOUSEWIFE															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
MARYLAND		-----		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		514 CATHEDRAL ST. 21201											
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST									
WILLIAM		BYRON		FANN		GRACE		ADELL		STANLEY									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
NO		215.46.9685		WILLIAM H. FANN		2210 PINESWOOD AVE. BALTO., MD. 21214													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUETO, OR AS A CONSEQUENCE OF													
4292				Arteriosclerotic cardiovascular disease															
				(b)		DUETO, OR AS A CONSEQUENCE OF													
				(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Hormez R. Guard, M.D.		Assistant		9/26/82															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE													
CREMATION		10/8/1982		GREEN MOUNT CREMATORY		BALTO. MD.													
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
WALTER BROOKS BRADLEY, INC.		DUNDALK, MD. 21222		OCT 11 1982		John J. Conner													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

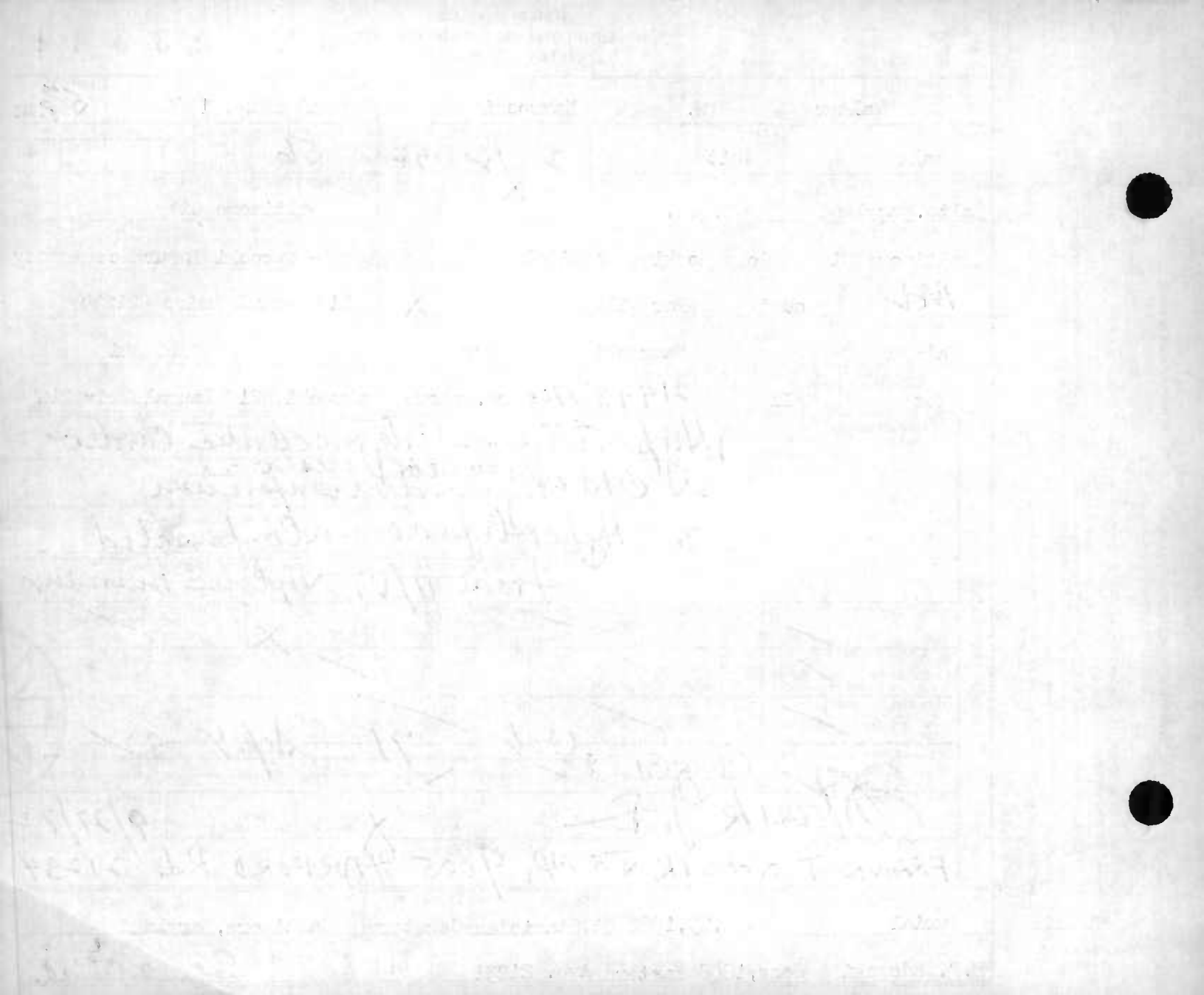
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with a 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	2	2	3	3	4	1
FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Walter M. Nawrocki										2a. DATE OF DEATH MONTH DAY YEAR September 25, 1982				2b. HOUR 5:30 P.M.		
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 12 26		6 AGE (IN YEARS LAST BIRTHDAY) 56 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.										
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John Hopkins Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Agent-Nawrocki Insurance Agency		12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD										13c. CITY OR TOWN Parkville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8219 Laural Drive 21234		
14. FATHER'S NAME FIRST MIDDLE LAST Walter Nawrocki				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Dubinski												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT Mrs. Dolores Nawrocki		ADDRESS 8219 Laural Drive 21234										
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 2721 IMMEDIATE CAUSE: 1. Hypertensive Arteriosclerotic Cardiovascular Disease 2. Old Myocardial Infarction 3. Hyperlipidemia Compensated DUE TO OR AS A CONSEQUENCE OF: PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Grade II/V, Systolic murmur										APPROPRIATE INTERVAL BETWEEN DEATH AND DEATH						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital attended) the deceased from <u>Aug 31</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death)										22b. SIGNATURE Frank T Kasik Jr MD		22c. DATE SIGNED 9/27/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANK T KASIK JR MD										22e. ADDRESS 9005 HARTFORD RD 21234						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 29, 1982		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland										
24. FUNERAL DIRECTOR NAME M.F. Sadowski & Sons, 1808 Eastern Ave. 21231				25a. DATE REC'D. BY REGISTRAR SEP 28 1982		25b. REGISTRAR'S SIGNATURE John J. Casich										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

DHMH-16 50M 1/B1
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 3 3 4 2	
FOR 1. STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Evelyn G. Neighbors</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>Sept. 24, 1982</i>			2b. HOUR M.		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Oct. 25, 1930</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>51</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i>			MD.		
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE, GIVE STREET ADDRESS) <i>1220 William St. Balto. Md. 21230</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Machinist, Md. Cup Co.</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>						13b. COUNTY		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Grover Cleveland Knott</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Cliffy Leo Huffer</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>223-36-3292</i>		17. INFORMANT ADDRESS <i>Mr. Merle Neighbors, Same as above</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Melanoma Malignant Melanoma</i> <i>1729</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mos</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <i>None</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (U) (this hospital) attended the deceased from <i>9-23, 19 82</i> , to <i>9-24, 19 82</i> , that (U) (we) last saw the deceased alive on <i>9-23, 19 82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (U) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Alfred Daniels MD</i>				DEGREE <i>MD</i>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>9/24/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Alfred Daniels MD</i>				22e. ADDRESS <i>510 E. Fort Ave Balto. Md 21230</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>Sept. 26, 1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Church Cemt.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Mt. Solon Virginia</i>			
24. FUNERAL DIRECTOR NAME <i>McCully Funeral Home, 130 E. Fort Ave. Balto. Md.</i>				ADDRESS <i>21230</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 29 1982</i>		25b. REGISTRAR'S SIGNATURE <i>J. Conner</i>			

MEDICAL CERTIFICATION



RECEIVED

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 3 4 3

REG. NO.

1 - FOR
STATE
REGISTRAR

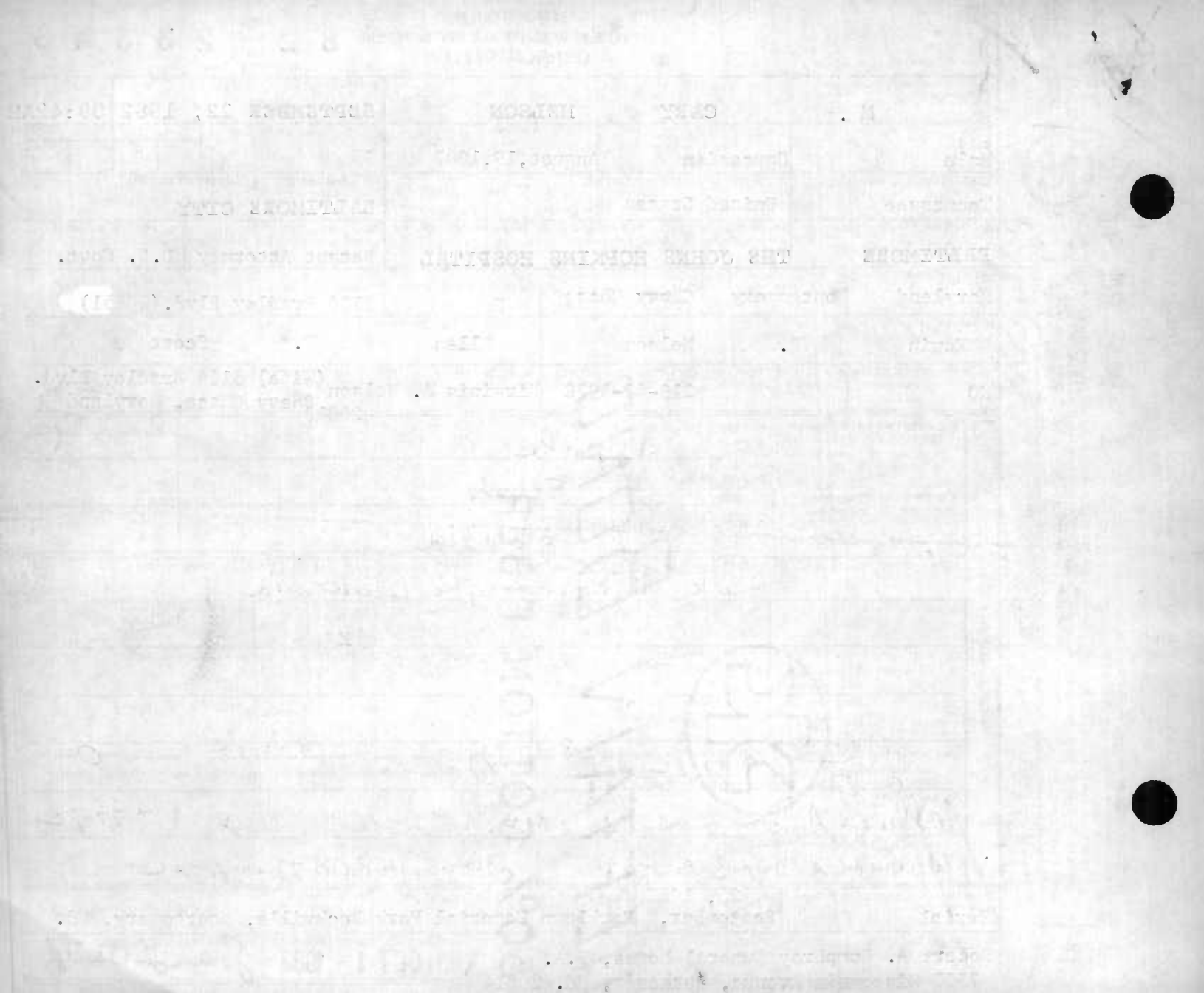
1. DECEASED NAME (TYPE OR PRINT) M. CARY NELSON			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 22, 1982		2b. HOUR 09:42AM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR August, 19, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Patent Attorney		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Chevy Chase	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 5124 Bradley Blvd. (208.15)	
14. FATHER'S NAME FIRST MIDDLE LAST Edwin R. Nelson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen P. Scott			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219-42-3972		17. INFORMANT (Wife) Virginia A. Nelson ADDRESS 5124 Bradley Blvd. Chevy Chase, Maryland 20815	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 7598 IMMEDIATE CAUSE (a) Asystole DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Aplasia					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Acute Myelomonocytic Leukemia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-27-82 , 19____, to 9-22-82 , 19____, that (I) (we) last saw the deceased alive on 9-22-82 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE William A. Dombrowski		DEGREE MD.		22c. DATE SIGNED 9-27-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM A. DOMBROWSKI		22e. ADDRESS JOHNS HOPKINS HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 25, 1982	23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Montgomery, Md.
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A. 7557 Wisconsin Avenue, Bethesda, Md. 20814			25a. DATE REC'D. BY REGISTRAR OCT 1 - 1982		25b. REGISTRAR'S SIGNATURE John J. Conner

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use as the burial-transit permit. The funeral director must move certain papers, printed on the back of this certificate, to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 2 2 3 3 4 4
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH A. NEUKAM		2a. DATE OF DEATH MONTH DAY YEAR 9-10-82		2b. HOUR 11:40 M	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 05 09 05	
6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO, MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME MAKER		12b. KIND OF BUSINESS OR INDUSTRY	
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSP.		13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13a. STATE MD		13b. CITY OR TOWN BALTO		13c. STREET ADDRESS 11 ELKHART CT.	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN AIRES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY E. GEPHART		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO. 219-28-8045		17. INFORMANT John C. Neukam, Sr.		ADDRESS 11 Elkhart Court Balto. MD 21237	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4151 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) PULMONARY EMBOLUS (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: RENAL FAILURE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/24 19 82 , to 9/10 19 82 , that (I) (we) lost saw the deceased alive on 9/10 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A. P. [Signature]		DEGREE MD		22c. DATE SIGNED 9/10/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. AIDEN WALSH, MD		22e. ADDRESS MERCY HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/13/82		23c. NAME OF CEMETERY OR CREMATORY Sacred Ht. of Jesus	
23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk, Baltimore, Maryland		24. FUNERAL DIRECTOR NAME DUDA-RUCK, INC.			
25a. DATE REC'D. BY REGISTRAR SEP 14 1982		25b. REGISTRAR'S SIGNATURE John J. Carver			

MEDICAL CERTIFICATION

2
9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

9-10-55

RECEIVED

STANDARD

STANDARD

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STANDARD

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE PENDING IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR TO EXECUTE THE CERTIFICATE. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR MOVAL.

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH		8 2 2 3 3 4 5 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE KNOWN OF DEATH	
DAVID NICHOLSON				2b. HOUR	
3. SEX male		4. RACE white		5. DATE OF BIRTH 9 / 26 / 1952	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kent Co. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland Penitentiary		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer Various	
13a. CITY OR TOWN Kent		13b. STREET ADDRESS Still Pond		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Luke Nicholson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Smith		16. SOCIAL SECURITY NO. 220 48 4513	
17. INFORMANT Luke Nicholson		18. ADDRESS Still Pond, Md.		19. DATE OF OPERATION	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hanging DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject hanged self		22. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
23a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		23b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Jail cell		23c. LOCATION Maryland Penitentiary	
24. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		25. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Jail cell		26. LOCATION Maryland Penitentiary	
27. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		28. ACTUAL SIGNATURE Margarita A. Korell, M.D.		29. DATE SIGNED 9-14-82	
30. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		31. DATE 9/16/82		32. NAME OF CEMETERY OR CREMATORY Still Pond Cem.	
33. LOCATION Still Pond, Md.		34. DATE REC'D. BY REGISTRAR SEP 17 1982		35. REGISTRAR'S SIGNATURE John J. Smith	



1970-1971

1971-1972

1972-1973

1973-1974

1974-1975

1975-1976

1976-1977

1977-1978

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1983-1984

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1987-1988

1988-1989



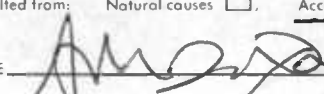
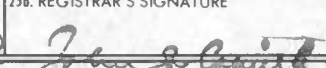
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST JESSE			MIDDLE LEE			LAST NINER			2a. DATE OF DEATH KNOWN ESTI- MATED <input checked="" type="checkbox"/> 9-28-82 <input type="checkbox"/> 19		2b. HOUR 19					
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR AUG. 18 81		6. AGE (IN YEARS) LAST BIRTHDAY) 1 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9-28-82 19		7d. HOUR 12:04 a.m.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City							
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none				12b. KIND OF BUSINESS OR INDUSTRY none					
13a. STATE Md.				13b. CITY OR TOWN Pr. Geo.				13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6527 Livingston Rd.									
14. FATHER'S NAME FIRST MIDDLE LAST Jeffrey A. Niner						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Melinda M. Wheaton													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. none				17. INFORMANT ADDRESS Jeffrey A. Niner same as item 13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8121 IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 6:55 PM 9-27-82 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) passenger of auto/auto collision											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hwy.				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 5 and Surratts Rd. Clinton, Maryland											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant								DATE SIGNED 9-28-82							
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, N.D.				ADDRESS 111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10/1/82				23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Alex. Va.							
24. FUNERAL DIRECTOR NAME G.P. Kalas								25a. DATE REC'D. BY REGISTRAR OCT 4 1982								25b. REGISTRAR'S SIGNATURE 			

BP

Male

Cauc.

1950. 10 21

Wash. D.C.

USA

None

None

Mr.

Mr. Geo.

Mr. Hill

Mr.

1950. 10 21

Jeffrey

A.

Mr.

Mr. Hill

Mr.

1950. 10 21

None

None

None

Jeffrey A. Hill as 1950. 10 21

1950. 10 21

Jeffrey

Mr. Hill

Mr. Hill

Mr.

1950. 10 21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B, states any injury, or other traumatic event, the medical examiner must be called to the scene.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 2 2 3 3 4 7 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Charles William Nizer						2a. DATE OF DEATH MONTH DAY YEAR September 20 1982		2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 21 1910		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Die Maker		12b. KIND OF BUSINESS OR INDUSTRY Paper Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7 Fairway Road 21221	
14. FATHER'S NAME FIRST MIDDLE LAST Nicholas Nizer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth 7					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT Marie Nizer, Wife		ADDRESS Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chronic Obstructive Pulmonary Disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>October 8</u> 19 <u>80</u> to <u>present</u> 19 <u>82</u> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>August 30</u> 19 <u>82</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.									
22b. SIGNATURE <u>Eric L. Weisbrot, M.D.</u>				22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22d. DATE SIGNED 9/21/82	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Eric L. Weisbrot, M.D.				22f. ADDRESS 406 Eastern Blvd. Balto., Md. 21221					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 9/24/82		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.			
24. FUNERAL DIRECTOR <u>Edward J. Zinski</u>				24a. ADDRESS Funeral Home PA 1407 Old Eastern Ave		25a. DATE REC'D. BY REGISTRAR SEP 22 1982			
24b. REGISTRAR'S SIGNATURE <u>John J. Gamm</u>				25b. REGISTRAR'S SIGNATURE					

October 1, 1955

United States District Court

100-25-100

File

Info

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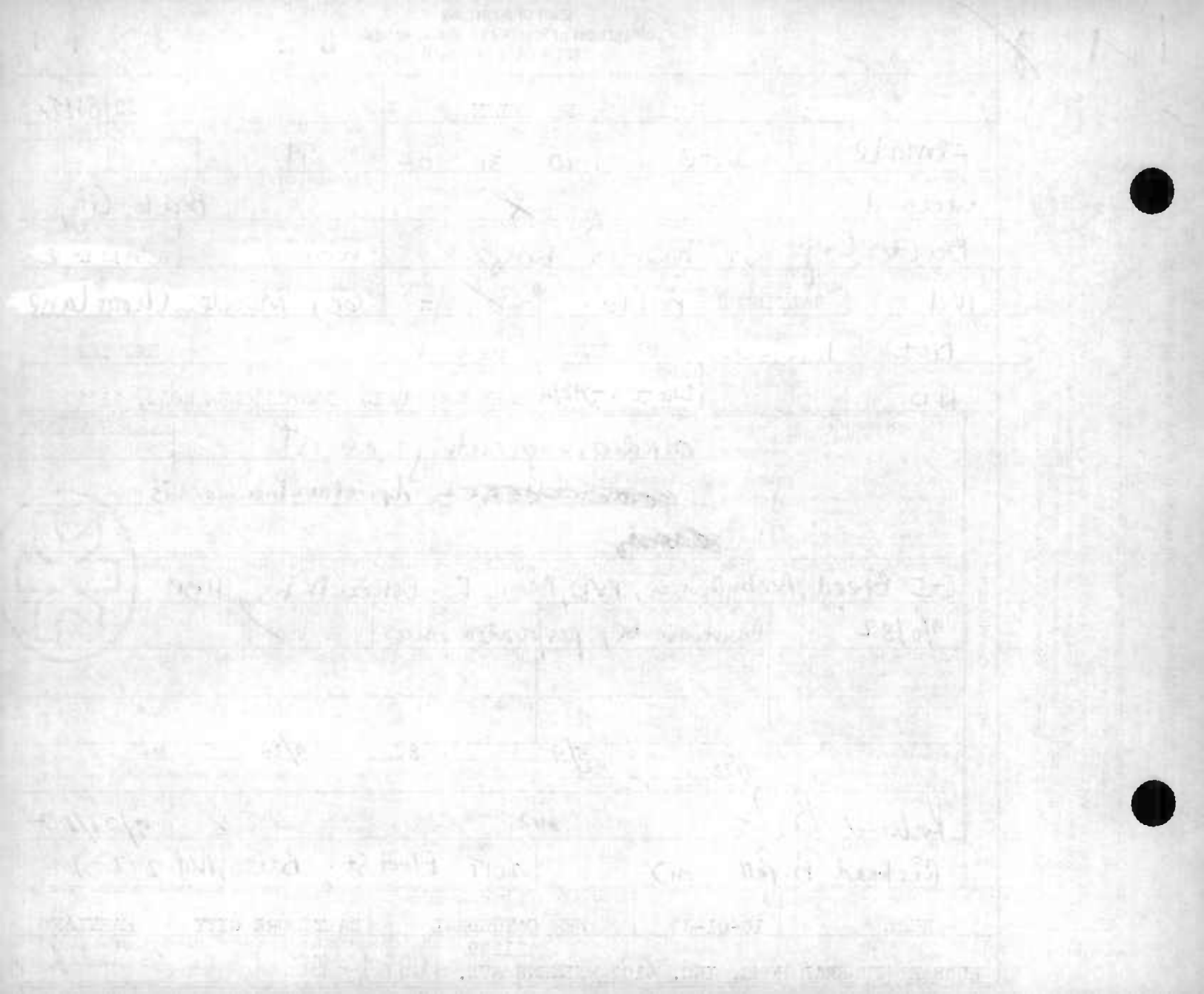
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 2 2 3 3 4 8
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		9 28 82		8:15 PM	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		white		MONTH DAY YEAR		99 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Ireland		USA				Balto City, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Balto City		ST. AGNES hosp.		BUYER		DEPT. STORE	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND		BALTIMORE		CATONSVILLE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		216-03-3424		MARY LOU QAID 300 OSBORNE ROAD, 21228	
JOHN		O'NEILL				HIGGINS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
PART I. DEATH WAS CAUSED BY: 5070 IMMEDIATE CAUSE (a) cardiorespiratory arrest		9/11/82		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
DUE TO, OR AS A CONSEQUENCE OF (b) cardiorespiratory arrest Aspiration Pneumonia		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
DUE TO, OR AS A CONSEQUENCE OF (c) cardiorespiratory arrest		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		21g. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21h. INJURY OCCURRED		21i. LOCATION STREET CITY OR TOWN COUNTY STATE	
GI Bleed, Arrhythmia, PVD, Atrial Fib, Osteoarthritis, HBP		21j. INJURY OCCURRED		21k. LOCATION STREET CITY OR TOWN COUNTY STATE		21l. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/9, 19 82, to 9/20, 19 82, that (I) (we) last saw the deceased alive on 9/20, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
		Richard B. Patis		9/28/82		Richard B. Patis, MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		10-01-82		NEW CATHEDRAL		BALTIMORE CITY MARYLAND	
24. FUNERAL DIRECTOR NAME		24a. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
HUBBARD FUNERAL HOME, INC.		4107 WILKENS AVE.		OCT 1 - 1982		John J. Conish	



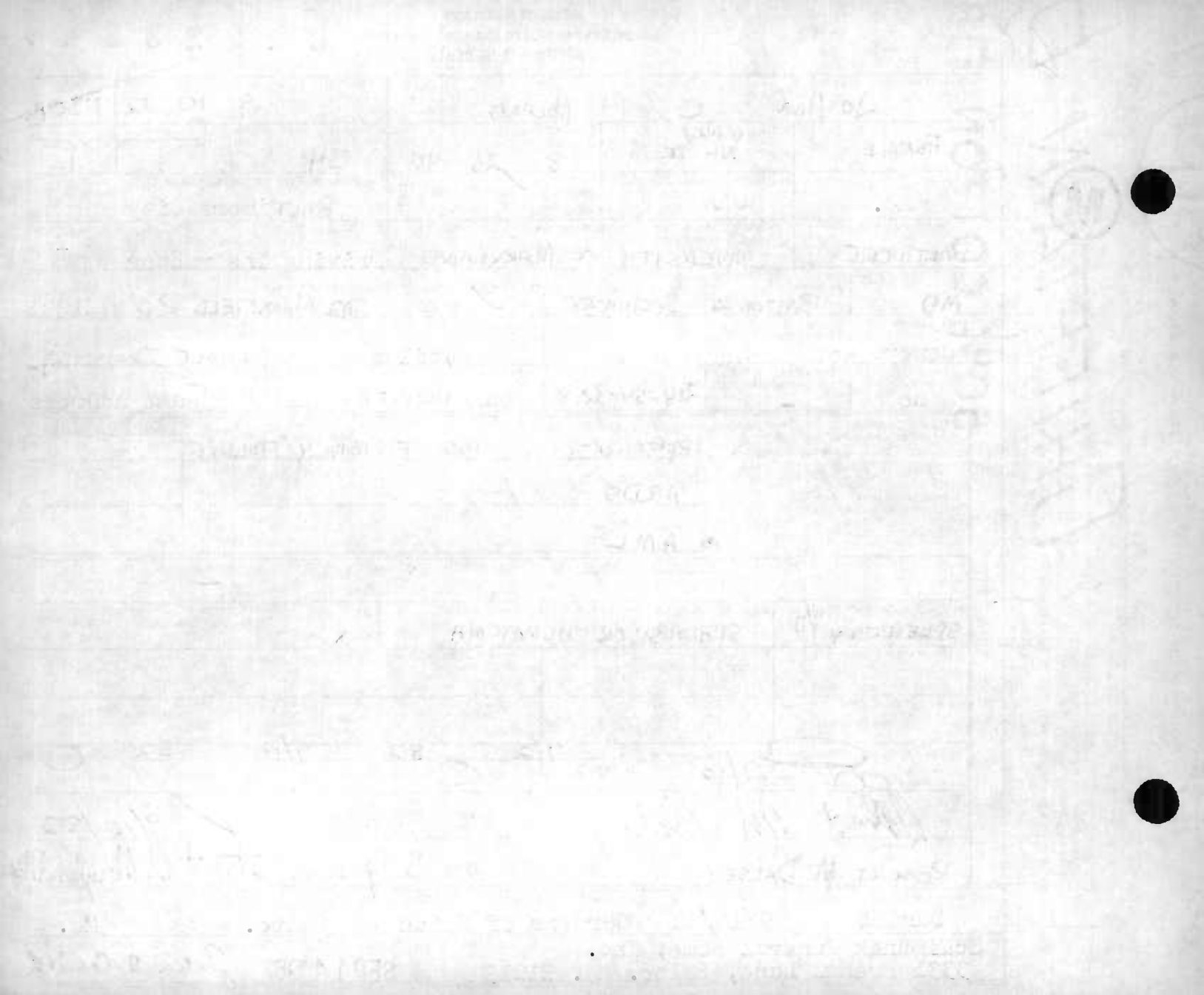
Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 3 3 4 9 REG. NO.					
1. FOR STATE REGISTRAR					1. DECEASED NAME (TYPE OR PRINT) JO-ANN C. NOLAND					2a. DATE OF DEATH MONTH DAY YEAR 9 10 82				2b. HOUR 7:30 P.M.	
3. SEX FEMALE		4. RACE (CAUC) WHITE		5. DATE OF BIRTH MONTH DAY YEAR 8 26 48		6. AGE (IN YEARS LAST BIRTHDAY) 34 YRS.				IF UNDER 1 YEAR MONTHS DAYS 34		IF UNDER 24 HRS HOURS MIN. 34			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD.									
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MARYLAND				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driving Instructor				12b. KIND OF BUSINESS OR INDUSTRY -					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD		13c. COUNTY BALTIMORE		13d. CITY OR TOWN BALTIMORE		13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13f. STREET ADDRESS 72 MANSFIELD RD 21221							
14. FATHER'S NAME FIRST MIDDLE LAST Dewey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Matilda Ackermann											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 214-54-3288		17. INFORMANT ADDRESS Dale Noland (husband) same address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY INSUFFICIENCY/FAILURE 2050 DUE TO, OR AS A CONSEQUENCE OF (b) ARDS DUE TO, OR AS A CONSEQUENCE OF (c) AML Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:															
19a. DATE OF OPERATION 9/7				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED SUBCAPSULAR HEMATOMA				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (i) (this hospital) attended the deceased from 9/2 19 82 , to 9/10 19 82 , that (ii) (we) saw the deceased live on 9/10 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)															
22b. SIGNATURE Robert M. Dalsey				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 9/10/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT M. DALSEY				22e. ADDRESS 22 S. Green Street U. Maryland Hospital											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9/14/82		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith				23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.					
24. FUNERAL DIRECTOR Schimmek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213								25a. DATE REC'D. BY REGISTRAR SEP 14 1982						25b. REGISTRAR'S SIGNATURE John J. Carver	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the certificate for burial or cremation. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 3 3 5 0 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) John E. Noz				2a. DATE OF DEATH MONTH DAY YEAR 9-18-82		2b. HOUR 9 50 PM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 10-11-1913		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City - Baltimore, MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY Container Mnfg.	
13a. STATE Md.				13b. COUNTY ---		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST John				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Marchiodi			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT Baltimore, Md. 21224. Miss Loretta D. Noz -146 N. Curley St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Carcinoma of The Lung DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Malnutrition							
19a. DATE OF OPERATION ---		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ---		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/21 , 19 82 , to 9/18 , 19 82 , that (I) (we) lost saw the deceased alive on 9/18 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dorian S. St. Martin				DEGREE MD		22c. DATE SIGNED 9/18/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dorian S. St. Martin				22e. ADDRESS Mercy Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/22/82		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery - Baltimore, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME John A. Moran, Inc.				25a. DATE REC'D. BY REGISTRAR SEP 21 1982			
25b. REGISTRAR'S SIGNATURE John J. Canine							

BP

52-81-9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpages. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, check only injury, or other traumatic event, then medical examiner will not be needed.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 3-5 1
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GEORGE J. NUESLEIN			2a. DATE OF DEATH MONTH DAY YEAR 09. 30. 82		2b. HOUR 7:30 AM
3. SEX MALE	4. RACE C	5. DATE OF BIRTH MONTH DAY YEAR 03 - 09 - 09		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Operator		12b. KIND OF BUSINESS OR INDUSTRY Communications
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD		13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 1407 GLENDALE RD. BALTO. MD 21239	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Nueslein		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Benzing			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 216 - 03 - 5669		17. INFORMANT ADDRESS 21239 Florence Nueslein 1407 Glendale Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Myocardial Infarction, (Pulmonary embolism) DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Carcinoma of the stomach					
19a. DATE OF OPERATION 9-24-82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of the stomach		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (in this hospital) attended the deceased from 09-14 , 19 82 , to 09-30 , 19 82 , that I (we) last saw the deceased alive on 09-30 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, I (we) (did) (did not) view the body after death.					
22b. SIGNATURE Mehm Thien Thang		DEGREE MD		22c. DATE SIGNED 09.30.82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MEHM T. THANG		22e. ADDRESS GOOD SAMARITAN HOSP. BALTO. MD. 21239			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 2, '82		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park	
24. FUNERAL DIRECTOR NAME William E. Johnson		ADDRESS 8521 Loch Raven Blvd.		25a. DATE REC'D. BY REGISTRAR OCT 1 - 1982	
				25b. REGISTRAR'S SIGNATURE John J. Canine	



1970

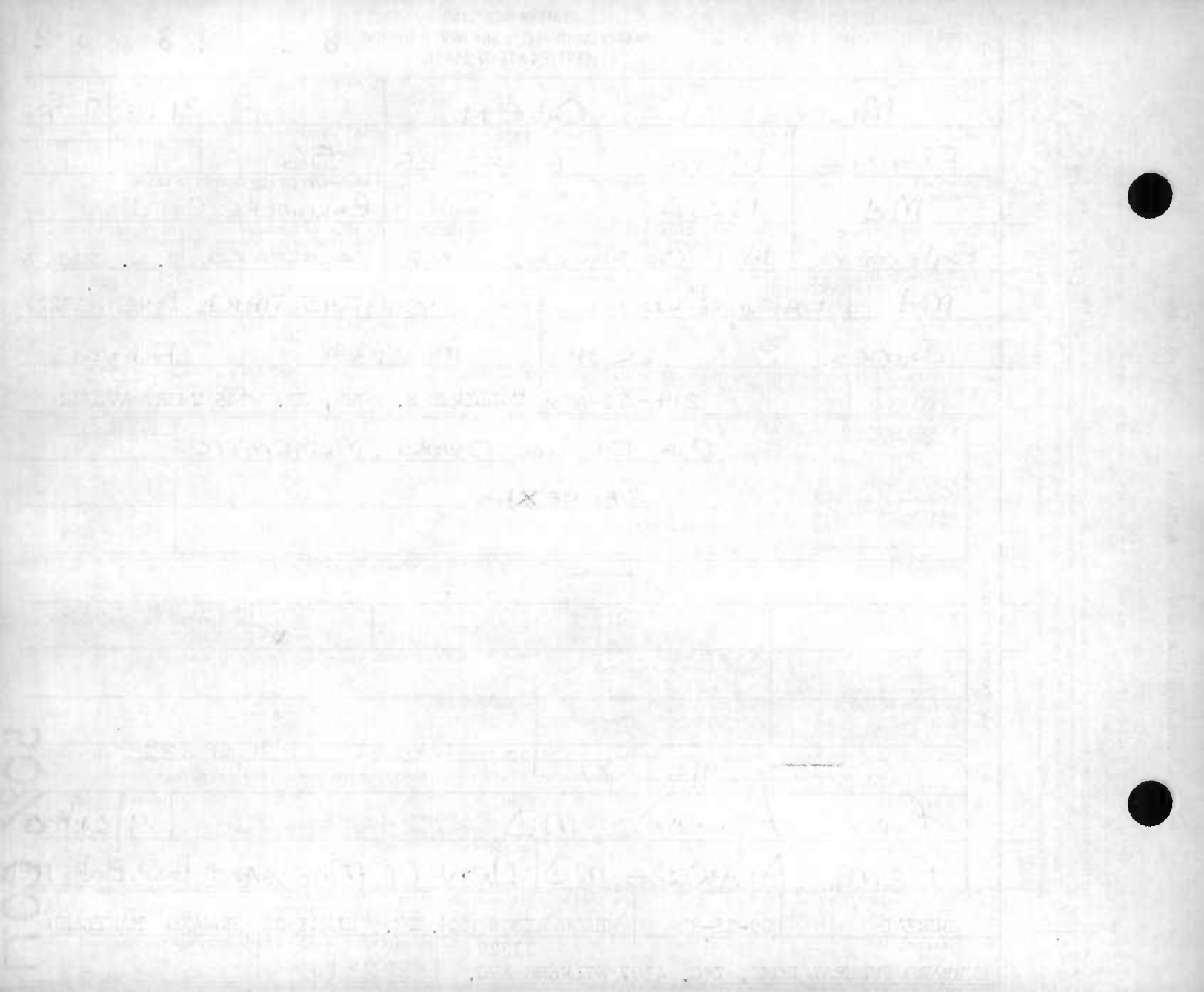
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 3 3 5 2 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) MILDRED LOUISE ODEN.						2a. DATE OF DEATH MONTH 9 DAY 21 YEAR 1982		2b. HOUR 9 25 P.M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 6 DAY 30 YEAR 26		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 		7. IF UNDER 24 HRS. HOURS MIN. 	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
12. CITY OR TOWN OF DEATH Baltimore		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. OF MARYLAND HOSP.				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY.		15. KIND OF BUSINESS OR INDUSTRY R. W. GRACE & CO.			
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md 13b. COUNTY BALTIMORE		13c. CITY OR TOWN Lansdowne		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 245 THIRD AVE. 21227					
14. FATHER'S NAME FIRST JAMES MIDDLE P LAST LEYN				15. MOTHER'S MAIDEN NAME FIRST MILDRED MIDDLE LAST FRANCIS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-20-6558		17. INFORMANT ADDRESS 21227 TOLLIVER S. ODEN, JR. 245 THIRD AVENUE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1830 IMMEDIATE CAUSE (a) CA OF THE OVARY, METASTATIC DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CACHEXIA DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 9/20 , 19 82 , to 9/21 , 19 82 , that (I) (we) lost saw the deceased alive on 9/21 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Remi Alawode, M.D.						DEGREE 		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/21/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Remi Alawode, M.D.						22e. ADDRESS UNIV. OF MARYLAND HOSP. Balto. Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 09-25-82		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE ELKRIDGE HOWARD MARYLAND					
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. ADDRESS 21229						25a. DATE REC'D. BY REGISTRAR SEP 23 1982		25b. REGISTRAR'S SIGNATURE [Signature]			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 3 5 3

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>June</u> M. MIDDLE <u>O'Neil</u> LAST		2a. DATE OF DEATH MONTH <u>SEPTEMBER</u> DAY <u>19</u> YEAR <u>1982</u>		2b. HOUR <u>7:40AM</u>	
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH <u>June</u> DAY <u>18</u> YEAR <u>1934</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>48</u> YRS. MONTHS <u></u> DAYS <u></u> HOURS <u></u> MIN. <u></u>	
10. CITY OR TOWN OF DEATH <u>BALTIMORE</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>THE JOHNS HOPKINS HOSPITAL</u>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTIMORE CITY</u> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Clerk</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>			
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Middle River</u>	
14. FATHER'S NAME FIRST <u>Andrew</u> MIDDLE <u>Gummer</u> LAST		15. MOTHER'S MAIDEN NAME FIRST <u>Helen</u> MIDDLE <u>Pollen</u> LAST		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>220-30-6115</u>		17. INFORMANT ADDRESS <u>Wilson O'Neil Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory arrest</u> 2126					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>pneumonia</u>					<u>3 days</u>
(c) <u>thymoma</u>					<u>16 yrs</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>					
19a. DATE OF OPERATION <u></u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u></u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED <u></u>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u></u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9/15</u> , 19 <u>82</u> , to <u>9/19</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>9/19/82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Richard A. Lange</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/19/82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>RICHARD A. LANGE</u>		22e. ADDRESS <u>JOHNS HOPKINS HOSP 600 N WOLFEST BALTIMORE</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>9-22-82</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cem.</u>	
23d. LOCATION CITY OR TOWN <u>Baltimore Co.,</u> COUNTY <u>Md.</u> STATE		23e. DATE REC'D. BY REGISTRAR <u>SEP 22 1982</u>			
24. FUNERAL DIRECTOR <u>Grudzinski Funeral Home</u>		25a. DATE REC'D. BY REGISTRAR <u>SEP 22 1982</u>			
25b. REGISTRAR'S SIGNATURE <u>John J. L...</u>					

MEDICAL CERTIFICATION

10.0

48

June 1, 1934

also

female

x

1934

female

June 1, 1934

also

female

June 1, 1934

also

female

June 1, 1934

also

June 1, 1934

also

female

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Junior W Osburn			2a. DATE KNOWN OF DEATH ESTIMATED 9 23 19 82			2b. HOUR 12:51 a.m.			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec 30, 1945	6. AGE (IN YEARS) (LAST BIRTHDAY) 36 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD 9 23 19 82			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3113 White Ave 21214	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Osburn			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Velma Marie Skidmore						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 215-44-2086		17. INFORMANT Mrs Ruby F Osburn		ADDRESS Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE Thomas D. Smith			M.D. Deputy Chief			MEDICAL EXAMINER		DATE SIGNED 9/23/82	
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.			ADDRESS 111 Penn ST. Balto., MD.						
23a. BURIAL, CREMATION, REMOVAL (SPEC.) Burial		23b. DATE 9/27/82		23c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR SEP 24 1982		25b. REGISTRAR'S SIGNATURE John J. Smith			



Handwritten signature or initials.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 172 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 2 3 3 5 5					
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 9 10 82				2b. HOUR 5p ^M	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANK J OSTROWSKI				6. AGE (IN YEARS LAST BIRTHDAY) 74				7b. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 1 HRS. HOURS MIN.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11 11 07		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH YRS. BALTO. CITY MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED	
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED				12b. KIND OF BUSINESS OR INDUSTRY 1 LA UNION	
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1910 EASTERN AVE	
14. FATHER'S NAME FIRST MIDDLE LAST FRANK OSTROWSKI				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MADELYN WALEGA					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 213-01-4147		17. INFORMANT ADDRESS 21227 Deichelman Rd 6407 Maple St			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest & massive CVA 4439 DUE TO, OR AS A CONSEQUENCE OF (b) massive stroke. 3 hrs. DUE TO, OR AS A CONSEQUENCE OF (c) Extra Cranial Peripheral Vascular dise. 20 yrs.								ADDITIONAL INTERVAL BETWEEN DEATH AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes									
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that this hospital attended the deceased from Sept 6, 1982, to Sept 10, 1982, that I (we) last saw the deceased alive on Sept 10, 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.									
22b. SIGNATURE Stuart Miller				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 9/10/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart Miller				22e. ADDRESS 900 Caton ave. Balto. md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9-14-82		23c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD			
24. FUNERAL DIRECTOR (NAME) John M. Weber & Sons, Inc.				ADDRESS 401 S CHESTER		25a. DATE RECD. BY HEALTH DEPT. SEP 15 1982		25b. RECEIVED BY HEALTH DEPT. John J. Conner	

9 10 29

FRANK J. COTTELL

WHITE 11 01

MARKING 124

CRIT. 124

NO. 124

FRANK J. COTTELL

NO. 124

CRIT. 124

NO. 124

CRIT. 124

NO. 124

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NO. 124

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JAMES M. OSWALD			2a. DATE OF DEATH MONTH DAY YEAR 09 05 82			2b. HOUR 100 P M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 11, 1932		6. AGE (IN YEARS, LAST BIRTHDAY) 50 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lawyer's Asst.		12b. KIND OF BUSINESS OR INDUSTRY Law Office		
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3209 N. Charles Street	
14. FATHER'S NAME FIRST MIDDLE LAST Edward James Oswald			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle R. Hehth							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korea 219 28 3938		17. INFORMANT Mrs. Myrtle R. Oswald,				ADDRESS Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hemorrhage into Respiratory Tract</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>BRONCHIOGENIC CARCINOMA, metastatic to liver</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that <u>he</u> (this hospital) attended the deceased from <u>September 5, 1982</u> , to <u>September 5, 1982</u> , that <u>he</u> (we) lost saw the deceased alive on <u>above</u> (b) (we) (did not see the body after death) and that in (my) (our) opinion death occurred on the date and hour and from the causes stated										
22b. SIGNATURE <u>A. Cool-Foley MD</u>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 9/5/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. Cool-Foley					22e. ADDRESS 201 E. University Pkwy.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/8/82		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Co., MD			
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>John J. Carlick</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 3 5 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DOROTHY M. OTTO			2a. DATE OF DEATH MONTH DAY YEAR 9 19 82		2b. HOUR 2 A M
1. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 21, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Walter L. Gettier			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine M. Young		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-01-4466		17. INFORMANT ADDRESS Albert L. Gettier 8411 Willow Oak Rd. 21234	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARDIAC ARREST 4275 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) ANOXIC ENCEPHALOPATHY					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 9-16 , 19 82 , to 9-19 , 19 82 , that (2) (we) last saw the deceased alive on 9-19 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert J. Varipapa MD				22c. DATE SIGNED 9/19/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT VARIPAPA MD				22e. ADDRESS UNION MEMORIAL HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sep 22 1982		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
23d. LOCATION CITY OR TOWN Baltimore		23e. COUNTY Maryland		23f. STATE Maryland	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland				25a. DATE RECD. BY REGISTRAR SEP 20 1982	
				25b. REGISTRAR'S SIGNATURE John J. Connelley	



DEATH CERTIFICATE

NAME: [illegible] SEX: [illegible] AGE: [illegible]
DATE OF BIRTH: [illegible] PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
SIGNATURE: [illegible]

CARDINAL

DEATH CERTIFICATE

X

DEATH CERTIFICATE

DEATH CERTIFICATE

100% COTTON FIBER

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS-401 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 2 3 3 5 8		
1- FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR
1. DECEASED NAME FIRST MIDDLE LAST Wesley Ouzts										2c. DATE ESTIMATED 9 23 1982		2d. HOUR 9:40
3. SEX MALE	4. RACE NEGROID	5. DATE OF BIRTH 5-1-23	6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD 9 23 1982		2d. HOUR 9:40		2e. HOUR a M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) FLORIDA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.						
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2128 Etting St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNEMPLOYED		12b. KIND OF BUSINESS OR INDUSTRY -				
13a. STATE MD.		13b. COUNTY -		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2128 ETTING ST.				
14. FATHER'S NAME FIRST MIDDLE LAST Grady Ouzts				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELLEN BURTON								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. WOWE 218-14-7685		17. INFORMANT EDDIE OUZTS		ADDRESS 424 ELLWOOD AVE.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Squamous cell carcinoma of tongue</u> 1419 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Pancreatitis												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Non-traumatic</u> <input checked="" type="checkbox"/> <u>Accident</u> <input type="checkbox"/> <u>Suicide</u> <input type="checkbox"/> <u>Homicide</u> <input type="checkbox"/> <u>Undetermined manner</u> <input type="checkbox"/> .												
ACTUAL SIGNATURE Thomas D. Smith				TITLE (SPECIFY) M.D. Deputy Chief				DATE SIGNED 9/23/82				
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-28-82		23c. NAME OF CEMETERY OR CREMATORY Crownsville VA cem.				23d. LOCATION Crownsville, MD.				
24. FUNERAL DIRECTOR NAME Calvin B. Scruggs				ADDRESS 1412 E. Preston St.				25a. DATE REC'D. BY REGISTRAR SEP 24 1982		25b. REGISTRAR'S SIGNATURE James J. Canine		

STANDARD
STANDARD
STANDARD

White House
Florida W. 2. A

Unemployed

Mr. B. L. B. L.

County Clerk
Hester, Burton
for work on the basis of

1900

General
John B. B. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, state any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 3 3 5 9	
1- FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) NETTIE M. OWENS						2a. DATE OF DEATH MONTH DAY YEAR Sept. 19, 1982		2b. HOUR 10:00 P			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR December 15, 1993		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Home Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY home			
13a. STATE Md		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis Junction		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME FIRST MIDDLE LAST Charles L. Owens				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST N. Idele Hammond							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212 30 2539		17. INFORMANT 120465 Heming Lane Bowie, Maryland Catherine Beckner							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 2500 IMMEDIATE CAUSE (a) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (b) UNCONTROLLED DIABETIS MELLITUS DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WEEK 1 WEEK			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from SEPT. 2, 19 82 , to SEPT. 19, 19 82 , that (I) (we) last saw the deceased alive on SEPT. 19, 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Paul E. Gormley				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 9/19/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL E. GORMLEY M D				22e. ADDRESS 100 N. BROADWAY BALTO. MD. 21231 CHURCH HOSPITAL CORPORATION							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept 23, 1982		23c. NAME OF CEMETERY OR CREMATORY Savage Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Savage, Maryland					
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home, Laurel, Md				25a. DATE OF DECISION TO BURY OR CREAM SEP 28 1982		25b. REGISTRAR'S SIGNATURE [Signature]					

MEDICAL CERTIFICATION



December 12, 1933

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RECEIVED NOV 100 2400



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR Charles H. Padden					8 2 2 3 3 6 0 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES H PADDEN					2a. DATE OF DEATH MONTH DAY YEAR HOUR 9 15 82 11 31A M				
1. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 19 20		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONTROLS REP		12b. KIND OF BUSINESS OR INDUSTRY WESTINGHOUSE	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN ROSEDALE					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21237 1906 GOLDEN RING COURT		
14. FATHER'S NAME FIRST MIDDLE LAST ANTHONY PADDEN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIAN LIPP				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 180163034		17. INFORMANT ADDRESS RITA PADDEN 1906 GOLDEN RING CT.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) respiratory arrest (c) labial/posterior MI									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/13/82 19 82 , to 9/15 19 82 , that (I) (we) lost saw the deceased alive on 9/15 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE M. Amos					DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED / 9/15/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marie Amos					22e. ADDRESS MERCY HOSPITAL BALTO., MD.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9/18/82		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. BALTO. MD.		
24. FUNERAL DIRECTOR John J. Conner			ADDRESS 1211 Chesaco Ave		25a. DATE REC'D. BY REGISTRAR SEP 17 1982		25b. REGISTRAR'S SIGNATURE John J. Conner		

MEDICAL CERTIFICATION

9 9

BP

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Charles . London

PHASE 4

CHURCH

15 14 13

WHITE

17-18

BATHING CITY

U.S.A

19-20

HOSPITAL

MEET

19-20

HOSPITAL

MEET

19-20

CONTACTS FOR
19-20 GOLDEN KING COURT

19-20

19-20

19-20

19-20

180183031 WITH FARMER 1906 GOLDEN KING CT.

19-20

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19-20

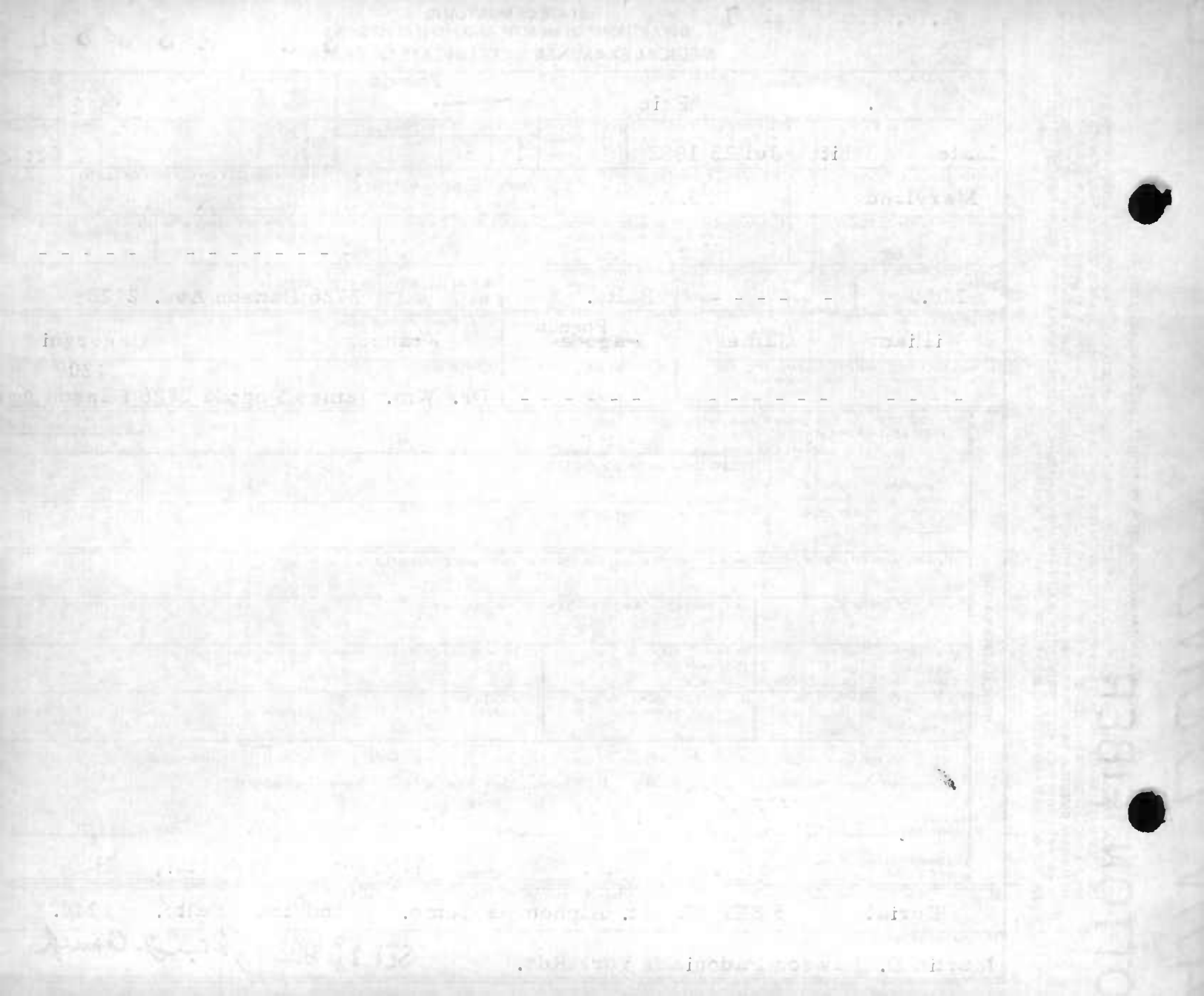
19-20 GOLDEN KING COURT

19-20 GOLDEN KING COURT

19-20

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

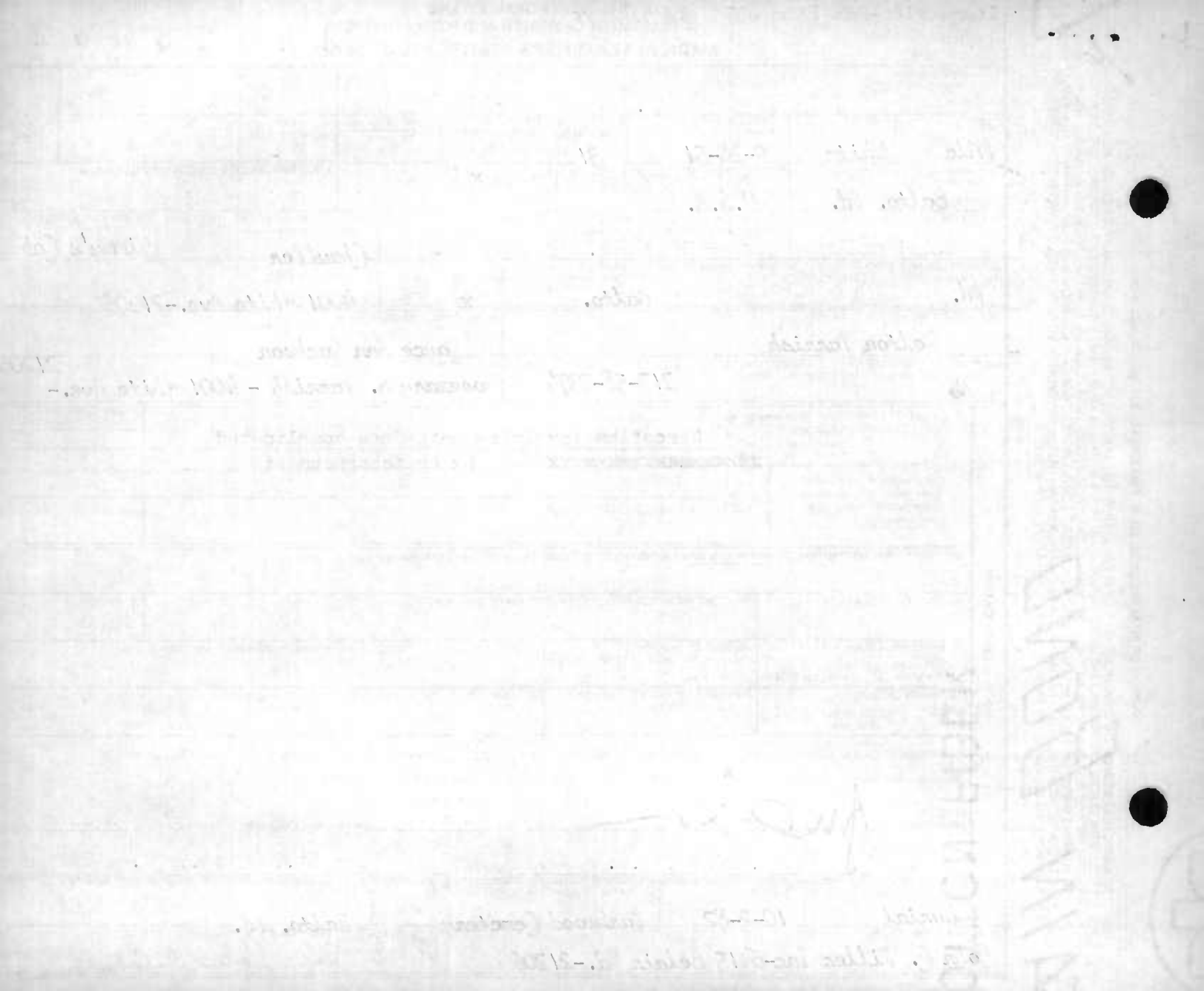
#1,14, Film G573 11/29/82 kam STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 23361	
1. DECEASED NAME (TYPE OR PRINT) W. Eric Pogoda										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 9 2 1982	
3. SEX Male		4. RACE White		5. DATE OF BIRTH (MONTH DAY YEAR) Jul 23 1982		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 1 DAYS 5		IF UNDER 1 YR. 1 IF UNDER 24 HRS. 5		2c. DATE PRONOUNCED DEAD 9 3 1982 12:12	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) - - - - -		12b. KIND OF BUSINESS OR INDUSTRY - - - - -	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY - - - - -		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2726 Hanson Ave. 21209			
14. FATHER'S NAME William James Pogoda						15. MOTHER'S MAIDEN NAME Frances Gheorghiu					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) - - - - -				16b. SOCIAL SECURITY NO. - - - - -		17. INFORMANT ADDRESS 21209 Dr. Wm. James Pogoda 2726 Hanson Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome 7980 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) - - - - - (c) - - - - -										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Hormez R. Guard, M.D.						TITLE (SPECIFY) Assistant		DATE SIGNED 9/3/82			
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.						ADDRESS 111 Penn Street, Balto., MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5 SEP 82		23c. NAME OF CEMETERY OR CREMATORY St. Alphonsus Ceme.		23d. LOCATION CITY OR TOWN COUNTY STATE Woodstock Balto. Md.			
24. FUNERAL DIRECTOR NAME Martin D. Lawson Padonia & York Rds.						25a. DATE REC'D. BY REGISTRAR SEP 10 1982		25b. REGISTRAR'S SIGNATURE John J. L...			



Items #18a-22a Film G573 11/24/82 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8 2 2 3 3 6 2

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
CHARLES W. PARRISH								9 29 1982								M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	White	9-28-51		31 YRS.						9 29 1982						10:25 a M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Balto. Md.		U.S.A.				Baltimore City										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		yard - 2700 blk. Bayonne Ave.		Chauffer		Jimmy's Cab											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md.				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4001 White Ave. - 21206									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Walton Parrish		Joyce Ann Jackson															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		217-58-9374		Rosemary A. Parrish		4001 White Ave. - 21206											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a)		Narcotism involving methadone complicated															
3040		by bronchopneumonia															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		(b)		DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		HOUR A.M. MONTH DAY YEAR															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION													
				CITY OR TOWN		COUNTY		STATE									
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
death resulted from		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Ann M. Dixon, M.D.		M.D. Assistant		9-29-82													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
		111 Penn St., Balto., Md. 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION											
Burial		10-2-82		Parkwood Cemetery		Balto. Md.											
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		REGISTRAR'S SIGNATURE									
John C. Miller Inc		6415 Belair Rd. - 21206				OCT 5 1982		John J. Canine									



STATE OF MARYLAND

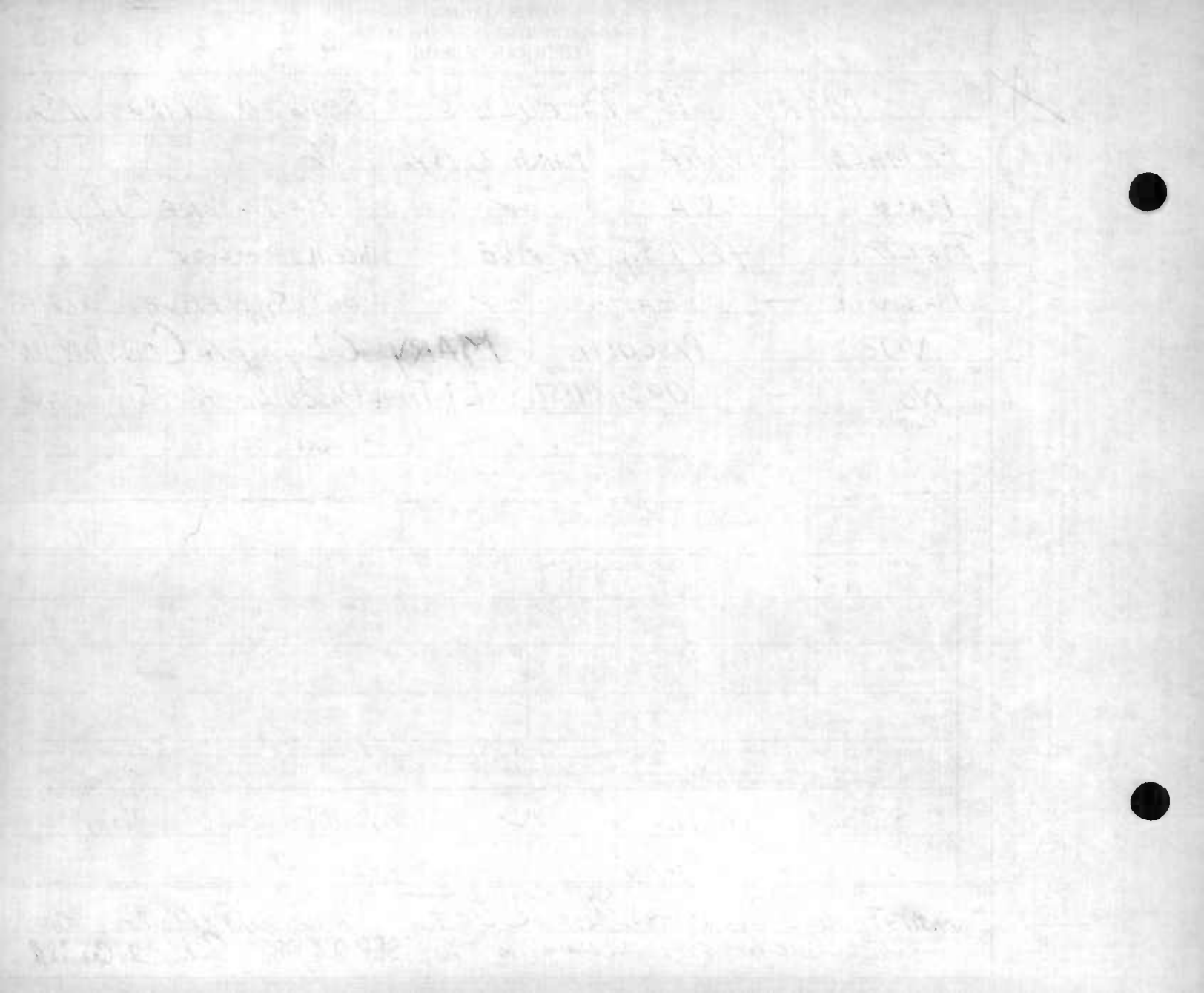
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 2 2 3 3 6 3
REG NO1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY P. PASCULLIS			2a DATE OF DEATH MONTH DAY YEAR SEPT. 20, 1982		2b HOUR 11:5 A.M.		
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR MARCH 31, 1896		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 86	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) ITALY		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10 CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4619 Sipple Ave		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NEEDLEWORK ARTIST		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE MARYLAND		13b COUNTY —		13c CITY OR TOWN BALTO.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST VITO PASCULLIS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY OLYMPIA CONSTANTIN		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No		16b SOCIAL SECURITY NO. 092-18-1857	
17 INFORMANT SISTER TINA PASCULLIS		ADDRESS 4619 Sipple Ave.		18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4140 antone sclerotic heart disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 9/18/80 19 82 , to 8/27 19 82 , that (I) (we) last saw the deceased alive on 8/27 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Julius H Goodman		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/21/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Julius H Goodman		22e. ADDRESS 5807 Harford Rd					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) TRANSIT + BURIAL		23b. DATE SEPT. 23 1982		23c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Macon, Bibbs Co., Ga.	
24. FUNERAL DIRECTOR NAME J. Walter Conkley		5444 ADDRESS BELAIR POND BALTO. MD.		25. DATE RECEIVED BY REGISTRAR SEP 24 1982		25b. REGISTRAR'S SIGNATURE John I. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

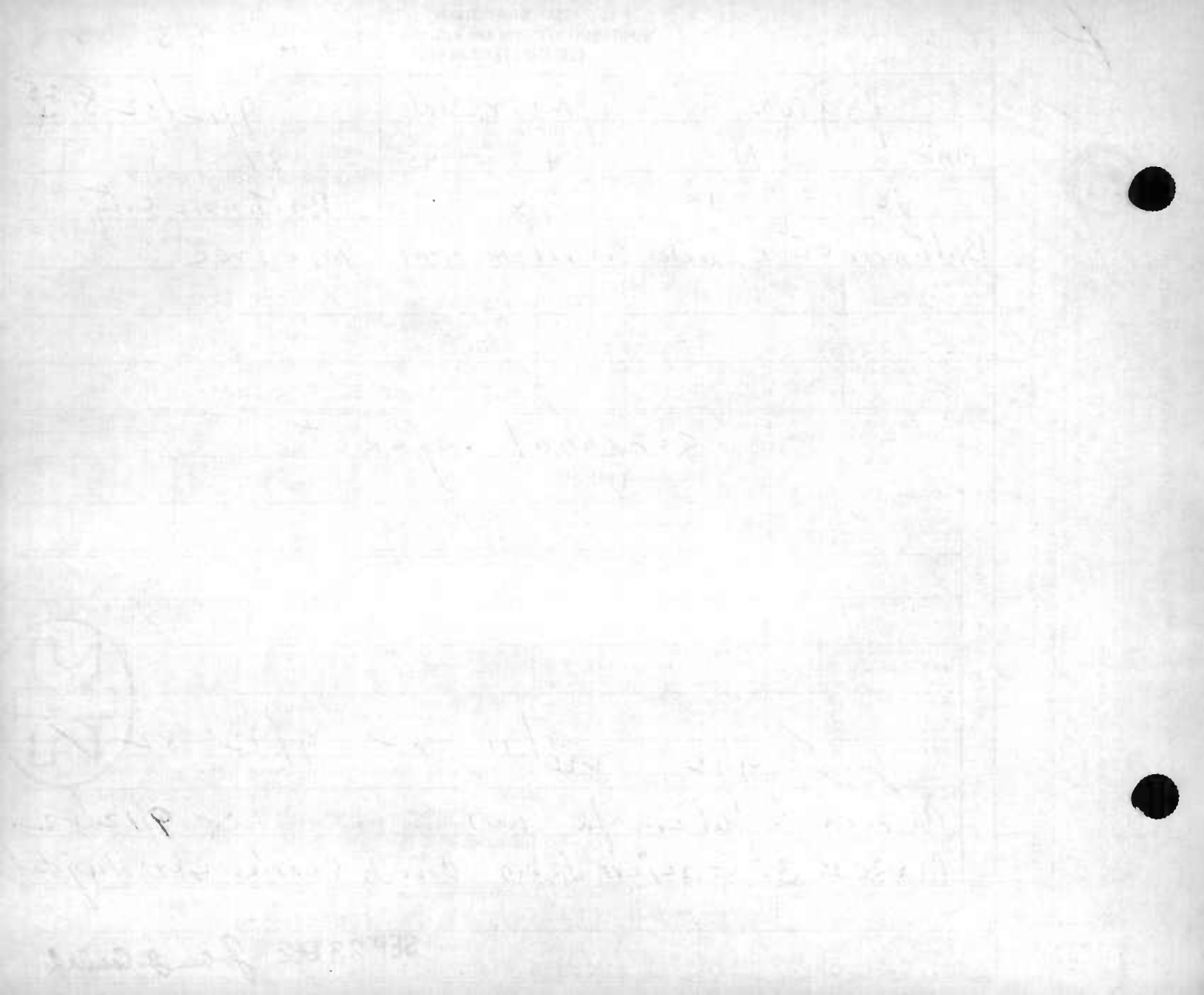


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PAYTON PATTERSON					2a. DATE OF DEATH MONTH DAY YEAR 9/12/82				
3. SEX MALE		4. RACE N		5. DATE OF BIRTH MONTH DAY YEAR 4 15 95		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		2b. HOUR 8:25 A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) N. Charles General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MINISTER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4 Milbert Court			
14. FATHER'S NAME FIRST MIDDLE LAST Rev. Harvey Patterson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-10-5147		17. INFORMANT ADDRESS Ruth Tyler 8537 Main Street					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4349 IMMEDIATE CAUSE (a) Cerebral infarct DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/11/82 to 9/12/82 , that (I) (we) last saw the deceased alive on 9/12/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)									
22b. SIGNATURE Marcos B. Galicia Jr., MD					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/12/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARCOS B. GALICIA JR. MD					22e. ADDRESS North Charles GEN. Hospital				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/16/82		23c. NAME OF CEMETERY OR CREMATORY King Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/ H1101 E. North avenue					25. PREPARED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 23 1982 John J. Carver				



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8

2

2

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3

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5

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) RICHARD PAYNE			2a. DATE OF DEATH MONTH DAY YEAR 9/27/82		2b. HOUR M	
3 SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 4/29/1902		6 AGE (IN YEARS LAST BIRTHDAY) 80		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. C.	7b. CITIZEN OF WHAT COUNTRY? U. S. A	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.		
10 CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5310 E Leith Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Forman Payne			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nicie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Marie Davis, 5310 Leith Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 5/1/82 , to June 1982 , that (I) (we) last saw the deceased alive on June 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE ARTHUR SIEBBAUS				DEGREE Good Samaritan Hospital		22c. DATE SIGNED 9/30/82
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct 2, 82		23c. NAME OF CEMETERY OR CREMATORY Mt Calvary		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland
24. FUNERAL DIRECTOR NAME ADDRESS Law Funeral Home 4611 Park Heights Ave.				25a. DATE REC'D. BY REGISTRAR SEP 30 1982		25b. REGISTRAR'S SIGNATURE John J. Canale

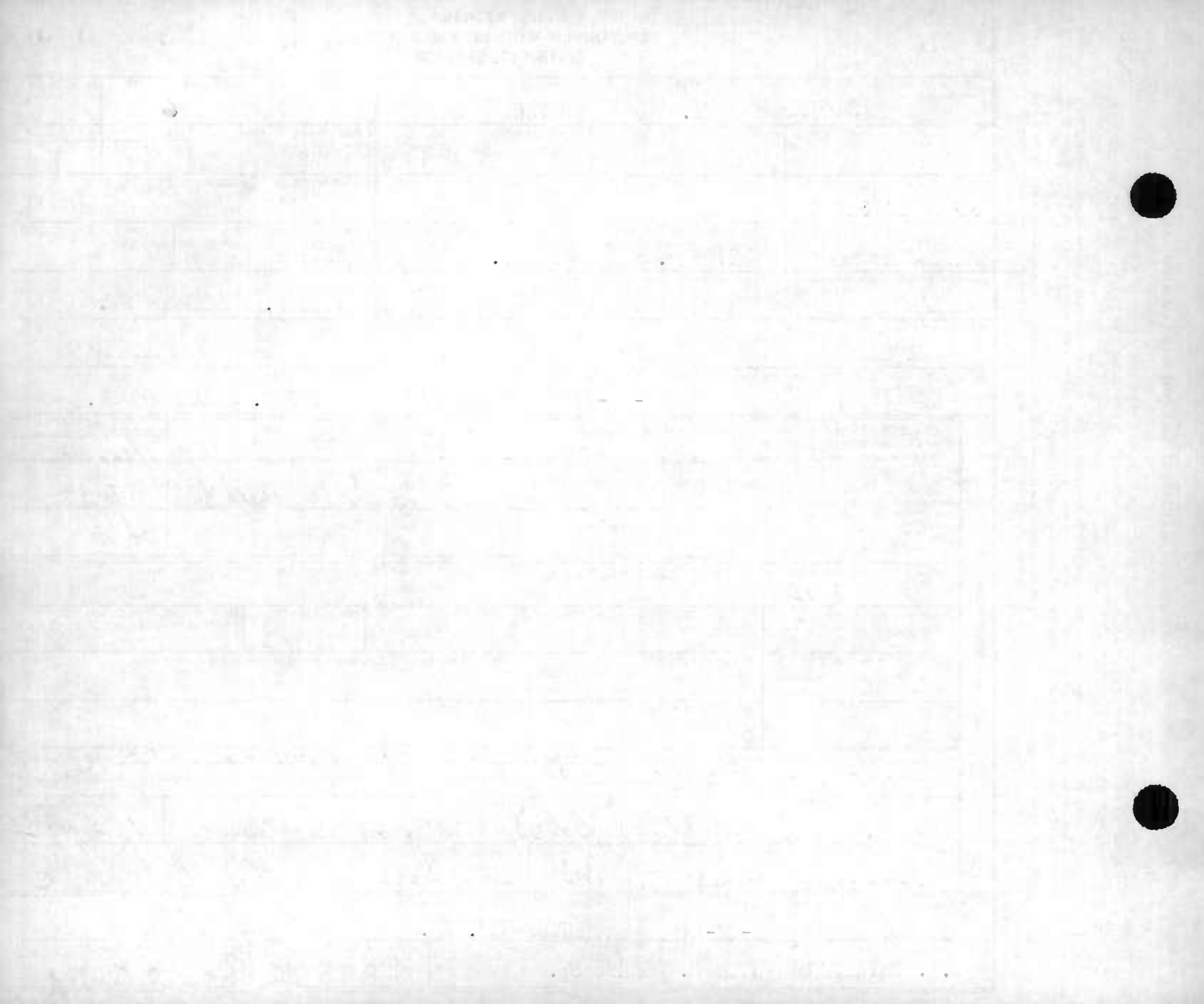
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 8 2 2 3 3 6 6							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SAMUEL L. PAYNE						2a. DATE OF DEATH MONTH DAY YEAR 9 16 82		2b. HOUR M	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 3 25 10		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2105 N. SMALLWOOD ST.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND						13b. COUNTY		13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST LONNIE PAYNE						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LUCY WILLIAMS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 248-05-7952		17. INFORMANT JULIA PAYNE		ADDRESS 2105 N. SMALLWOOD ST.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute MI</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD / Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>Years</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>CVA</u>									
19a. DATE OF OPERATION 9 9		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>April 18</u> , 19 <u>78</u> to <u>Aug 26</u> , 19 <u>82</u> , that (1) (we) lost <u>Aug 26</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.									
22b. SIGNATURE <u>Laurence Phillips, Jr. MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/20/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAURENCE PHILLIPS, JR. MD				22e. ADDRESS 5601 Lock Raven Blvd, Baltimore, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9-22-82		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR NAME E.L. PHILLIPS				ADDRESS 1721 N. MONROE ST.		25a. DATE REC'D. BY REGISTRAR SEP 23 1982		25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>	

1504 BP



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

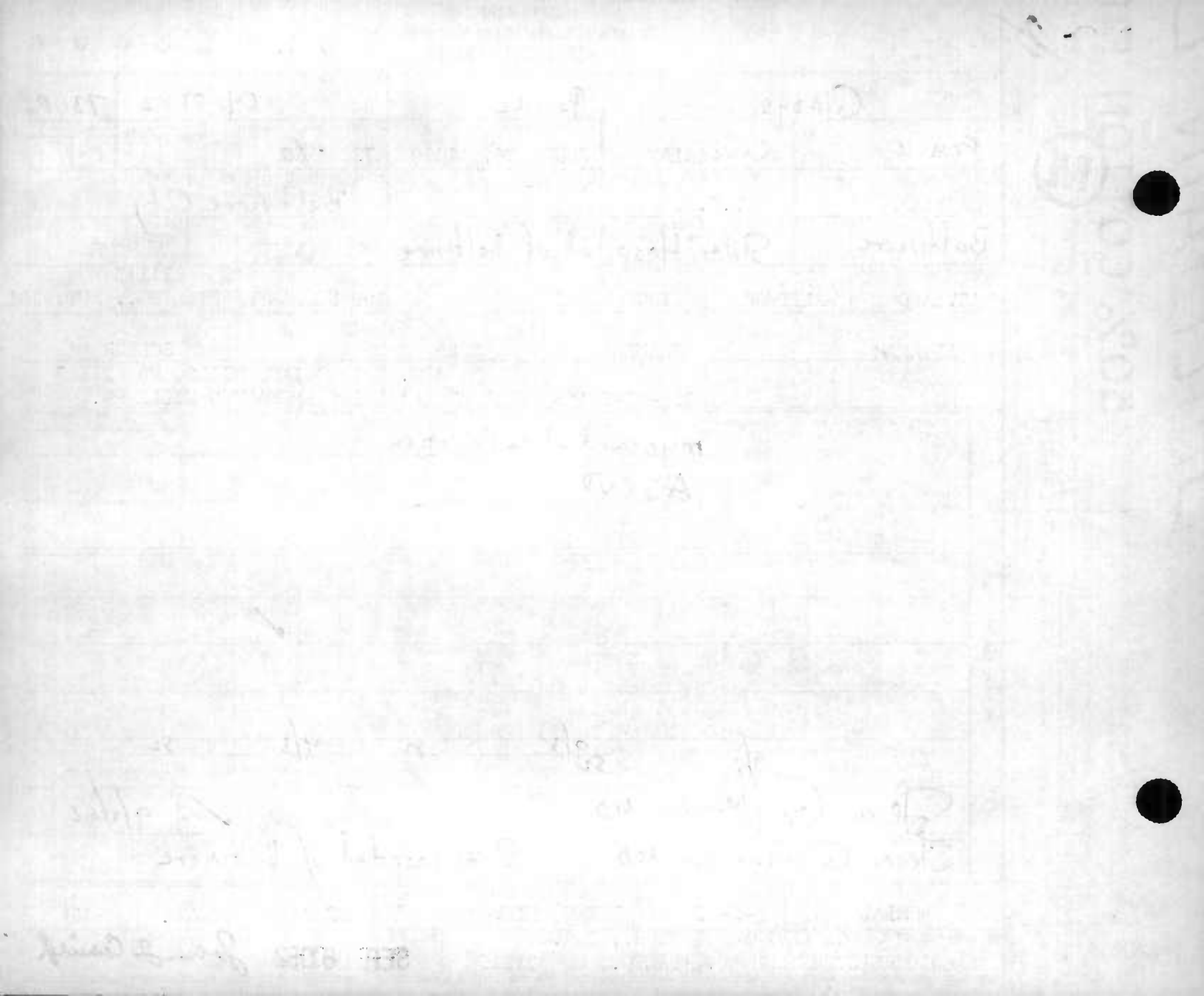
IMPORTANT: If item 21 is marked on item 18, sheets any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 3 6 7
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GLADYS - PEARL			2a. DATE OF DEATH MONTH DAY YEAR 09 03 82			2b. HOUR 731 P.M.			
3. SEX Female		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JUNE 26, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI Hospital of Baltimore				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN OWINGS MILLS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 109 ENCHANTED HILL RD., APT. 201	
14. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM FRANKLIN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE SCHERR					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-01-5018B		17. INFORMANT APT. 201 OWINGS MILLS, MD 21117 HERBERT PEARL 109 ENCHANTED HILLS RD.,					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/3 , 19 82 , to 9/3 , 19 82 , that (I) (we) last saw the deceased alive on 9/3 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (I) (we) (did) (did not) know the body after death.									
22b. SIGNATURE Steven Gufferman MD				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/3/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven Gufferman MD				22e. ADDRESS SINAI Hospital of Baltimore					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9-5-82		23c. NAME OF CEMETERY OR CREMATORY PETACH TIKVAH		23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO. MD			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR SEP 8 1982		25b. REGISTRAR'S SIGNATURE John J. Carver	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 2 3 3 6 8	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <i>Willie Pearson</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>9 1 1 82</i>			2b. HOUR <i>6 40</i> <i>AM</i>			
3. SEX <i>M</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>5 11 09</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>73</i> YRS. MONTHS <i>3</i> DAYS <i>20</i>		IF UNDER 1 YEAR <i>3</i> MONTHS <i>20</i> DAYS <i>20</i> HOURS <i>40</i> MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>S.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTO. CITY</i> MD.					
10. CITY OR TOWN OF DEATH <i>BALTO.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>SINAI HOSP.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Ret.</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>md.</i>					13b. COUNTY <i>BALTO.</i>		13c. CITY OR TOWN <i>BALTO.</i> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>3712 REISTERSTOWN Rd.</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>300 NELSON</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>DORA HILTON</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>					16b. SOCIAL SECURITY NO. <i>248-10-8140</i>		17. INFORMANT ADDRESS <i>MS. WILLIE MAE ALLEN-506 E. 36TH ST.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metabolic acidosis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>acute renal failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>dehydration</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>2765</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4 day</i> <i>6 day</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>cutting lesion rug (candida) malnutrition</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) this hospital attended the deceased from <i>July 7</i> , 19 <i>82</i> , to <i>Aug Sept 1</i> , 19 <i>82</i> , that (1) (we) last saw the deceased alive on <i>Sept 1</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>E. Zimmerman</i>					DEGREE		22c. DATE SIGNED <i>9/1/82</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Edward D Zimmerman</i>					22e. ADDRESS <i>Sinai Hospital</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b. DATE <i>9-4-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>King Mem. PK.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>RANDALLSTOWN, md.</i>				
24. FUNERAL DIRECTOR NAME <i>Redd FUNERAL Home - 5209 YORK Rd</i>					25a. DATE REC'D. BY REGISTRAR <i>SEP 7 1982</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>				



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HAZEL E. PEDERSON			2a. DATE OF DEATH MONTH 9 DAY 1 YEAR 82		2b. HOUR 8:00A
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH 5 DAY 22 YEAR 80		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY 21239 MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY BALTO	13c. CITY OR TOWN BALTO	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Charles MIDDLE Ristau LAST Elizabeth		15. MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE Bernisse LAST Bernisse			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 219-22-2310		17. INFORMANT ADDRESS Louis N. Pederson RD2 Box 5 Middleton, Del.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ASYSTOLE 4100 DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--	---

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) **Congestive Heart Failure**

19a. DATE OF OPERATION 8-27-82	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED FREE AIR IN PERITONEAL CAVITY	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-8-82 to 9-1-82 , that (I) (we) lost saw the deceased alive on 9-1-82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Francis Khoo		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 9-1-82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR FRANCIS KHOO		22e. ADDRESS GOOD SAMARITAN HOSPITAL	

23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE Sept. 4, 1982	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley	23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Maryland
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland ADDRESS		25a. DATE REC'D. BY REGISTRAR SEP 1 1982	25b. REGISTRAR'S SIGNATURE James J. Calvert

Conkeyville Maryland

Feb. 1, 1980

Dear Mr. [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

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[illegible]

[illegible]

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

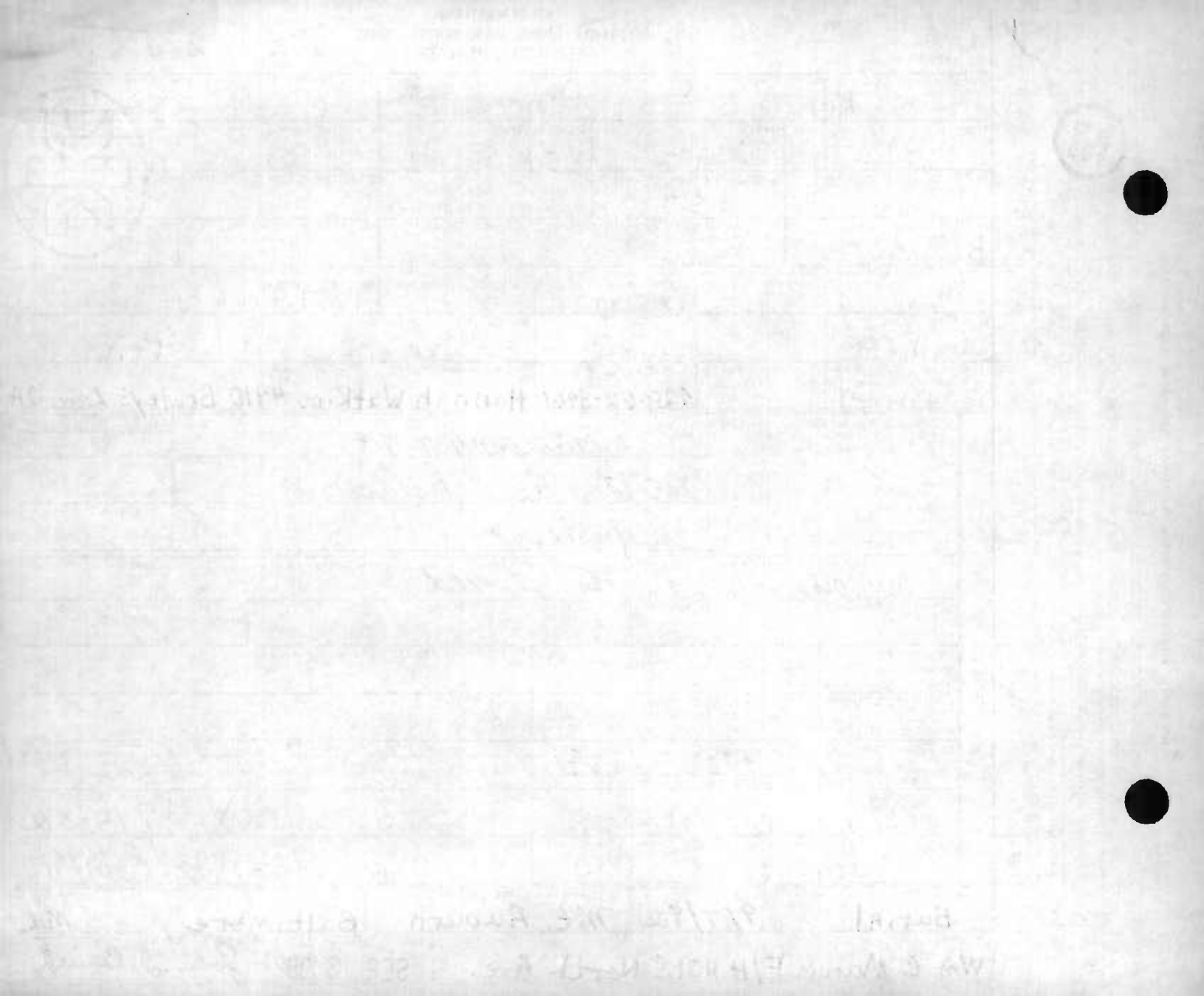
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Henry Penn					2a. DATE OF DEATH MONTH DAY YEAR 9 2 82		2b. HOUR 4052 AM		
3. SEX m		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 04 01 47		6. AGE (IN YEARS LAST BIRTHDAY) 35 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.			
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1807 Fleet St 21231	
14. FATHER'S NAME FIRST MIDDLE LAST Willie Knight				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kay Penn					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Unknown				16b. SOCIAL SECURITY NO. 229-62-3460		17. INFORMANT ADDRESS Hannah Watkins 4410 Bowley's Lane 2A			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio pulmonary arrest</u> 5739 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>no tag liver disease</u> (c) <u>encephalopathy</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>hypothermia, ascites, GI bleed</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/15/82</u> , 19 <u>82</u> , to <u>9/2/82</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>9/2</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Marie A. Amos				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 9/2/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marie Amos MD				22e. ADDRESS 321 Meigs Hospital Baltimore					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/7/82		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md		23e. DATE REC'D. BY REGISTRAR SEP 3 1982	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.				25a. REGISTRAR'S SIGNATURE John J. Conner					

MEDICAL CERTIFICATION

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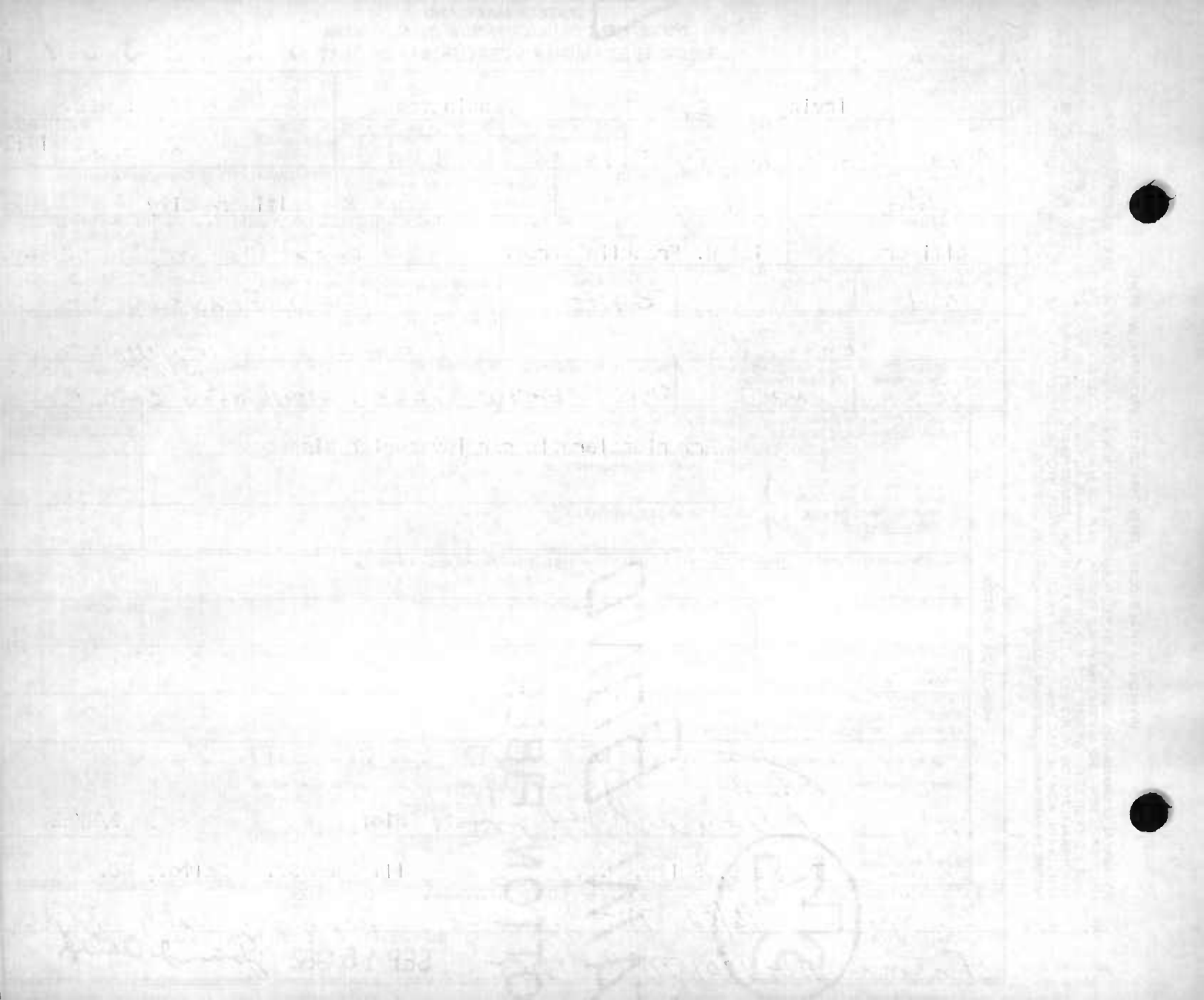
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 3 3 7 1	
1. DECEASED NAME (TYPE OR PRINT) Irving E. Pennington						2a. DATE OF DEATH KNOWN <input type="checkbox"/> ESTIMATED <input checked="" type="checkbox"/> 9 8 1982		2b. HOUR M			
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 12 18 15		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 66		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD 9 9 1982	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 124 W. Franklin Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Postal (Retired)		12b. KIND OF BUSINESS OR INDUSTRY Civil serv.			
12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12b. STATE Md.		12b. COUNTY BALTO		13. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 124 W. Franklin St			
14. FATHER'S NAME FIRST MIDDLE LAST Unknown						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Pennington					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS Ms VANESSA PENNINGTON Balto. Md 21239					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Thomas D. Smith, M.D.				TITLE (SPECIFY) Deputy Chief				MEDICAL EXAMINER DATE SIGNED 9/9/82			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/16/82		23c. NAME OF CEMETERY OR CREMATORY Mt Zion AME				23d. LOCATION CITY OR TOWN COUNTY STATE Long Green Balto. Md.			
24. FUNERAL DIRECTOR NAME Chatman F/H 1701 McCulloch St				25a. DATE REC'D. BY REGISTRAR SEP 15 1982				25b. REGISTRAR'S SIGNATURE John J. Conish			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified about it.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 3 7 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gertrude Perry			2a. DATE OF DEATH MONTH DAY YEAR 9-11-82			2b. HOUR 30 P.M.			
3. SEX F		4. RACE C		5. DATE OF BIRTH MONTH DAY YEAR 1 2 1893		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD.			
12. CITY OR TOWN OF DEATH BALTO		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MANOR CARE Nursing Center				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		15. KIND OF BUSINESS OR INDUSTRY HOME	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE Maryland 12b. COUNTY Baltimore			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 24 N. LAKEWOOD AVE		
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH BUTKA			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARYANNA KASZEWSKA			16. ADDRESS 2124 AVE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 214-16-3648		17. INFORMANT (WATSON) PERRY		17a. ADDRESS 24 N. LAKEWOOD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Alzheimer's disease 3310 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9/28/82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 78 9/11/82		21g. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (I) (the hospital) attended the deceased from 9/11/82 to 9/11/82 , that (I) (we) lost saw the deceased alive on 9/11/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.									
22b. SIGNATURE Nejthun			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/14/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. M. TUN			22e. ADDRESS 2110 pot spring Road md 21092						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9-15-82		23c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEM		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD		
24. FUNERAL DIRECTOR NAME John M. Welter ADDRESS 4015			25a. DATE REC'D. BY REGISTRAR SEP 15 1982		25b. REGISTRAR'S SIGNATURE John J. Conish				

MEDICAL CERTIFICATION

TO HOSPITAL or ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 3 7 3
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mildred Scott Person		2a. DATE OF DEATH MONTH DAY YEAR 9 3 82		2b. HOUR M
3 SEX Female	4 RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 1 4 1908		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, Maryland MD.
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2611 Garrison Boulevard		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic	12b. KIND OF BUSINESS OR INDUSTRY Pvt. Families
13a. STATE Maryland		13b. COUNTY Baltimore	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Scott		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 217-03-9378		17. INFORMANT Oakland ADDRESS California 94601 Mr. Ara Person 2375 E. 27th Street
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> 4029 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>1976</u> 19____, to <u>1982</u> 19____, that (I) (we) lost saw the deceased alive on <u>AUG. 30</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>Richard M. Hunt</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-10-82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Richard Hunt		22e. ADDRESS MD 800 Braddish Avenue, Baltimore, Md. 21217		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/9/82	23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County, Maryland		23e. DATE REC'D. BY REGISTRAR SEP 9 1982		
24. FUNERAL DIRECTOR NAME HERBERT F. NATION FUNERAL HOME 3035 W. NORTH AVENUE		25. REGISTRAR'S SIGNATURE <u>John J. Lauer</u>		

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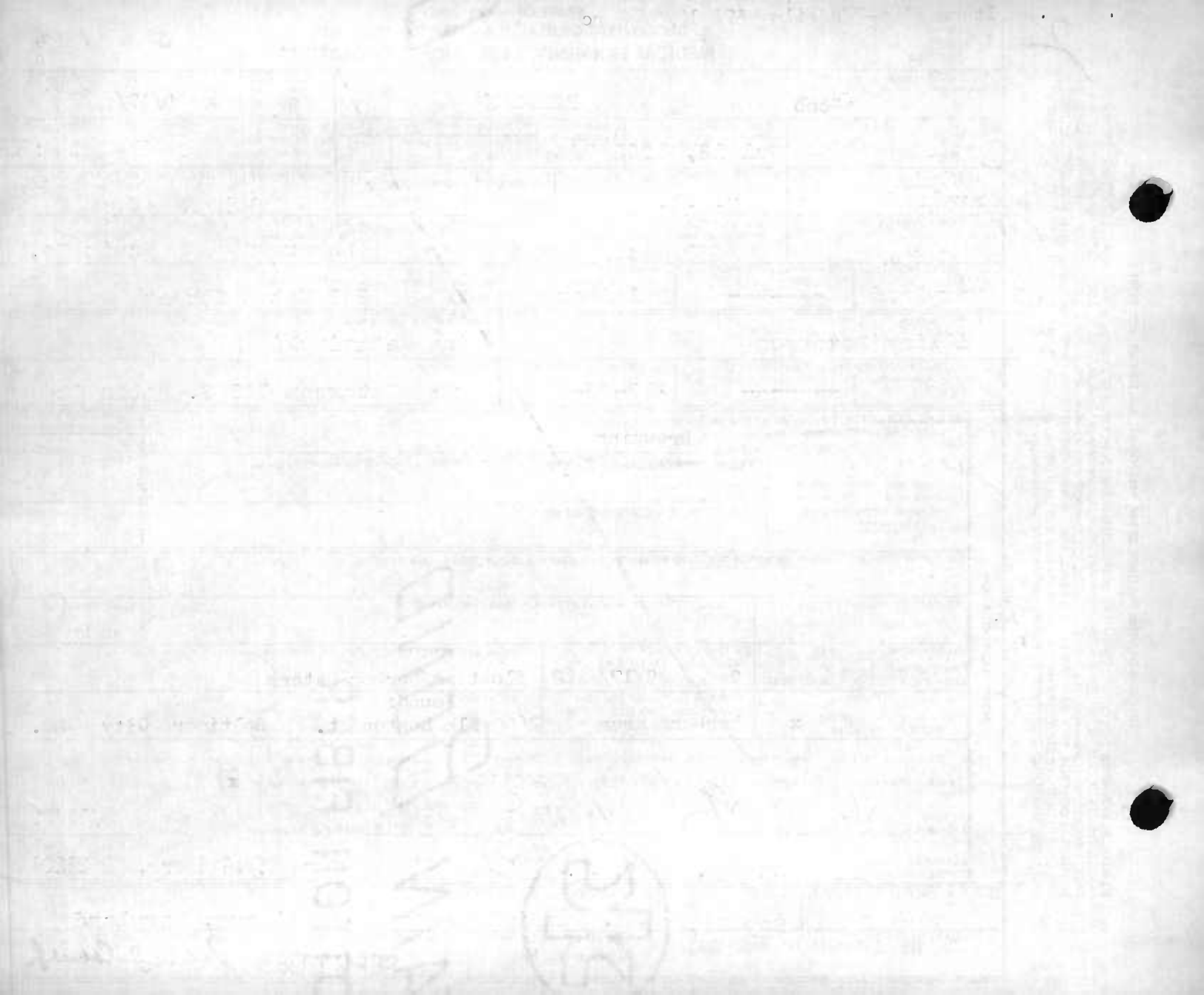
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 WITH VITAL RECORDS FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 2 3 3 7 4	
1. DECEASED NAME (TYPE OR PRINT) Jacob PETERSON						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 9/17/1982		2b. HOUR M			
1. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Jul 18, 1908	6. AGE (IN YEARS) LAST BIRTHDAY 74 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 17 1982		2d. HOUR 6:55A			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2600 Boston Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor		12b. KIND OF BUSINESS OR INDUSTRY Fruit Co.			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY -----		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 703 Eaton Street			
14. FATHER'S NAME FIRST MIDDLE LAST William Peterson						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tina Katazinski					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS Edward Peterson 703 S. Eaton St/						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 9840 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 9/17/1982			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) floating/harbor waters					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) harbora area			21f. LOCATION Found: STREET CITY OR TOWN COUNTY STATE 2600 Blk Boston St. Baltimore City Md.					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .						22b. Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE <i>Hormez R. Guard</i>			TITLE (SPECIFY) Assistant M.D.			MEDICAL EXAMINER		DATE SIGNED 9/17/82			
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D. (for)			ADDRESS 111 Penn Street, Baltimore, MD 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sep 21, 82		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland				
24. FUNERAL DIRECTOR NAME Dippel Funeral Homes, Inc.			ADDRESS 7110 Belair Road Baltimore, Md.			25a. DATE REC'D. BY REGISTRAR SEP 21 1982		25b. REGISTRAR'S SIGNATURE <i>John J. Canfield</i>			



1. DECEASED NAME (TYPE OR PRINT) MOSES			2. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY 9 YEAR 30 ₁₉ 82			7b. HOUR AM		
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Feb. 2, 1931	6. AGE (IN YEARS) (LAST BIRTHDAY) 51 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 30₁₉ 82	7d. HOUR 6:45	7e. MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Armed Services		12b. KIND OF BUSINESS OR INDUSTRY CW02
13a. STATE Maryland			13b. CITY OR TOWN Columbia	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 5559 High Tor Hill		
14. FATHER'S NAME FIRST MIDDLE LAST Moses Peterson, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie Mimms					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) -		16b. SOCIAL SECURITY NO. 418-38-8171		17. INFORMANT Columbia, Md ADDRESS 21045 Jennifer Peterson, 5559 High Tor Hill		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thermal Injuries 78120 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).		
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:30 PM 9/30/82	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) driver/truck/explosion/fire
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway	21f. LOCATION STREET CITY OR TOWN COUNTY STATE Balto. City Line Woodlawn Balto. Co. Md.
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>		
ACTUAL SIGNATURE H R Guard		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.		DATE SIGNED 10/1/82

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/4/82	23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia
24. FUNERAL DIRECTOR NAME ADDRESS Witzke Columbia Funeral Home		25a. DATE REC'D. BY REGISTRAR OCT 5 1982	25b. REGISTRAR'S SIGNATURE John J. Canard

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Items 18b, c per phone 9/30/82 da STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- STATE REGISTRAR

REG. NO. 82 23376

1. DECEASED NAME (TYPE OR PRINT) JEANETTE M. Pfeiffer			2a. DATE OF DEATH MONTH DAY YEAR 9/26/82			2b. HOUR 05 9 PM			
3 SEX Female		4 RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR 3-29-04		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hyattsville Spouse Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Exton, Pa.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2400 Queen Chapel RD.	
14. FATHER'S NAME FIRST MIDDLE LAST Hude,			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. 51709 4877B		17. INFORMANT John D. Sp. Nursing Home-109 W. L. S. Ave.		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Cardio-pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction - DUE TO, OR AS A CONSEQUENCE OF (c) A SHD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Tardive Dyskinesia, Varicose veins									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9-7- 19 78 to 9-26- 19 82 , that (I) (we) lost saw the deceased alive on 9-26- 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Sumkat MD				DEGREE MD				22c. DATE SIGNED 9-26-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SUMKAT Y. KHAN				22e. ADDRESS 1528 King William Drive, Baltimore					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 9/29/82		23c. NAME OF CEMETERY OR CREMATORY Glen St Bernard		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR John D. Sp. Nursing Home				25a. DATE REC'D. BY REGISTRAR SEP 28 1982		REGISTRAR'S SIGNATURE John D. Sp. Nursing Home			

8/26/83

Transcript of Interview

14-00000-1004

WMA 11/11/83

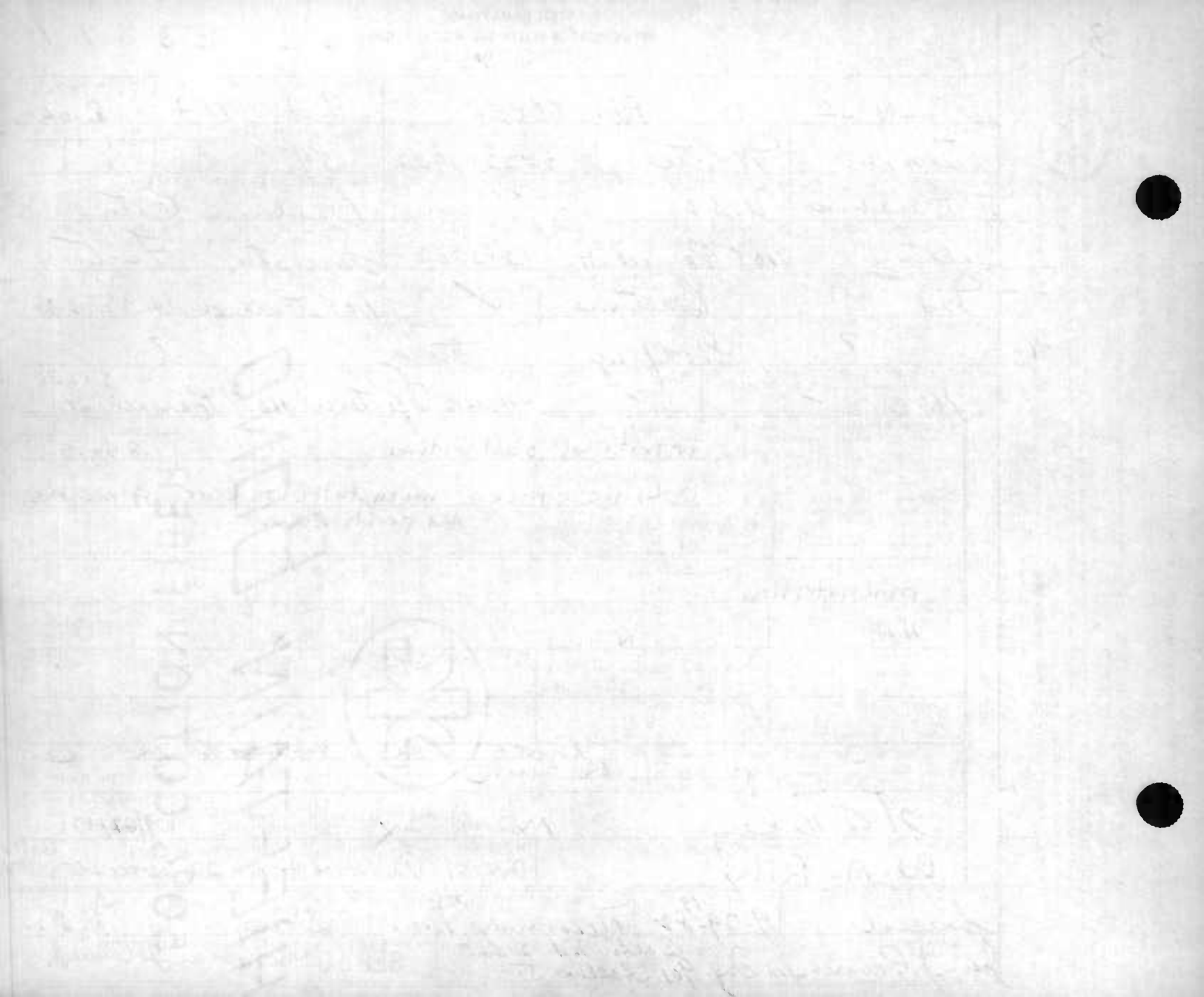
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 3 3 7 7			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) LOUISE D. PFISTERER				2a. DATE OF DEATH MONTH DAY YEAR 9-25-1982		2b. HOUR 8:20 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12-22-1922		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH. Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1105 Carroll St. 21230		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector		12b. KIND OF BUSINESS OR INDUSTRY Factory	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Ind		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST ? MIDDLE Gregory LAST ?		15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE ? LAST ?		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. -	
17. INFORMANT Harold Pfisterer		ADDRESS 1105 Carroll St. 21230		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) intestinal obstruction DUE TO, OR AS A CONSEQUENCE OF (b) colonic cancer - metastatic to liver and peritoneum DUE TO, OR AS A CONSEQUENCE OF (c) 1		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: malnutrition							
19a. DATE OF OPERATION N.A.		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N.A.		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from August 5 , 19 82 , to September 25 , 19 82 , that (1) (we) last saw the deceased alive on September 2 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE W. A. Riley		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/27/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. A. Riley		22e. ADDRESS Box 151 Univ. of Md Hosp. 22 S. Greene St. Balto Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-29-82		23c. NAME OF CEMETERY OR CREMATORY Greenwood Mem.		23d. LOCATION CITY OR TOWN COUNTY STATE Dorsey Ind.	
24. FUNERAL DIRECTOR NAME John J. Cowan & Son, Inc.		ADDRESS 901 Acclens St. Balt. Md. 21223		25a. DATE REC'D. BY REGISTRAR SEP 30 1982 REGISTRAR'S SIGNATURE John J. Cowan			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 3 7 8

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MILDRED VIRGINIA PFISTERER			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 10, 1982		2b. HOUR A 5:00 M		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 3/23/1912		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 70 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO., MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 422 M. ROSE ST.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	
13a. STATE MARYLAND		13b. COUNTY ---		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM MISTER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY VIRGINIA WEBSTER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219.14.1818		17. INFORMANT ADDRESS MARGARET D. PEARCE 402 MERRIE LANE FALLSTON, MD. 21047			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Ca (Angioblastic) embolism

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>T. A. F. Brown</u> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/10/1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. A. F. Brown				22e. ADDRESS 223 EASTERN BLVD, ESSEX, MD, 21221			

23a. BURIAL, CREMATION, REMOVAL (SEE ITEM 18) BURIAL		23b. DATE 9/13/1982		23c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS WALTER BROOKS BRADLEY, INC., DUNDALK MD, 21222				25a. DATE REC'D. BY REGISTRAR SEP 14 1982		25b. REGISTRAR'S SIGNATURE <u>T. A. F. Brown</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be called at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 3 7 9

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MADORIS ELIZABETH PHILIPPI			2a. DATE OF DEATH MONTH 9 DAY 5 YEAR 82		2b. HOUR 7:10 AM
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH 4 DAY 22 YEAR 1917		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	# UNDER 1 YEAR MONTHS 0 DAYS 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) handcrafter		12b. KIND OF BUSINESS OR INDUSTRY tailor shop
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Raspeburg		
13c. CITY OR TOWN Raspeburg			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS 5415 Omaha Ave. 21206			13f. CITY OR TOWN Baltimore		
14. FATHER'S NAME FIRST Calvin MIDDLE Coleman, Sr. LAST Hofmann			15. MOTHER'S MAIDEN NAME FIRST Charlotte MIDDLE E. LAST Hofmann		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Arrest 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) MI Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minutes
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/4 , 19 82 , to 9/5 , 19 82 , that (I) (we) lost saw the deceased alive on 9/5 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Michael Shear MD		DEGREE MD		22c. DATE SIGNED 9/5/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Shear		22e. ADDRESS Union Memorial Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-8-82		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.	
23d. LOCATION CITY OR TOWN Parkville Baltimore, Md.		23e. DATE REC'D. BY REGISTRAR SEP 9 1982			
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home, 7401		ADDRESS Belair Rd.		25a. DATE REC'D. BY REGISTRAR SEP 9 1982	
25b. REGISTRAR'S SIGNATURE John J. Co...		25c. REGISTRAR'S SIGNATURE John J. Co...			

MEDICAL CERTIFICATION

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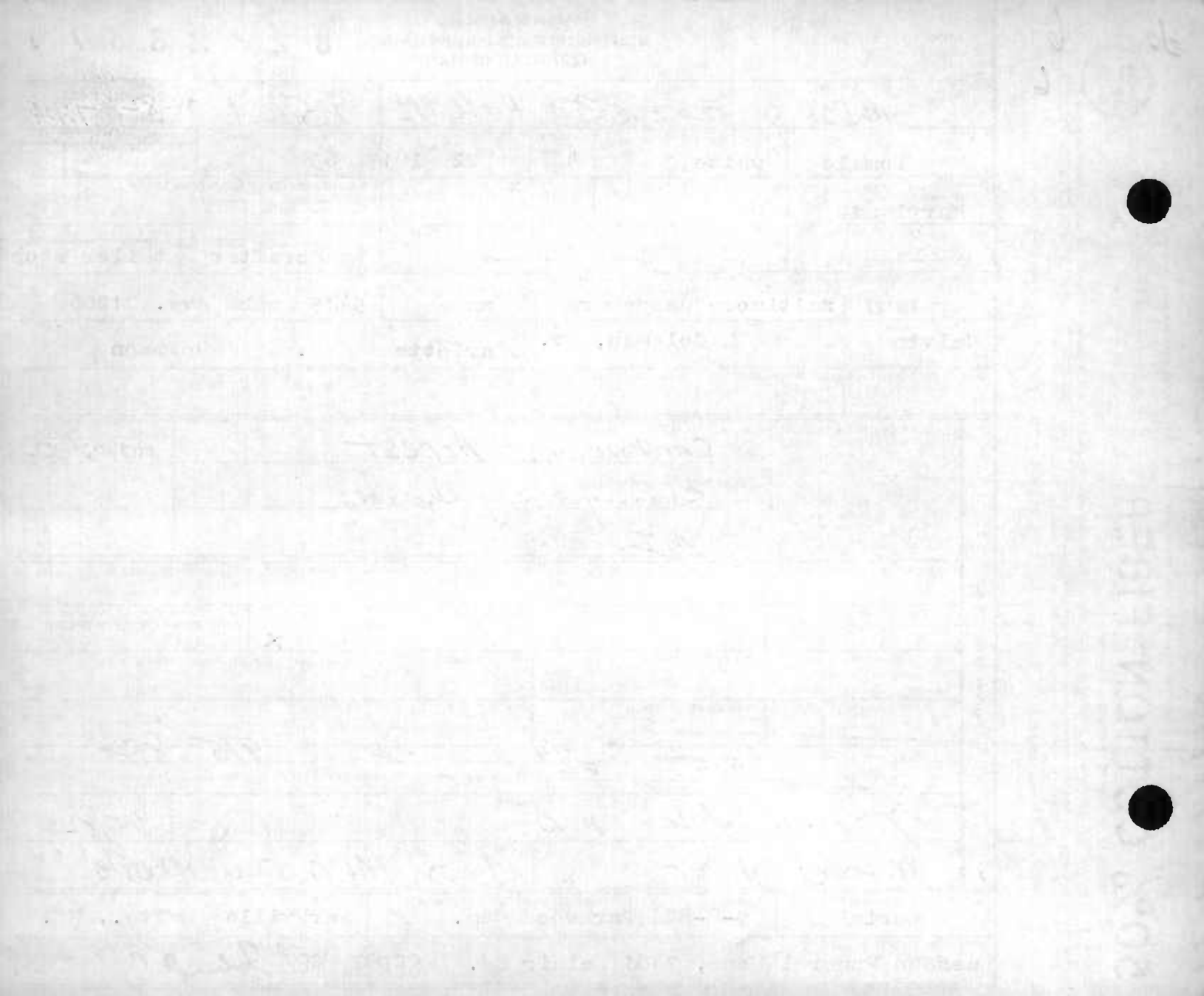
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 3 8 0
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Leelyne</u> MIDDLE <u>T.</u> LAST <u>Phillips</u> <u>Leelyne T. PHILLIPS</u>		2a. DATE OF DEATH MONTH <u>9</u> DAY <u>5</u> YEAR <u>82</u>		2b. HOUR <u>10</u> AM <u>30</u>	
3. SEX <u>Female</u>		4. RACE <u>Black</u>		5. DATE OF BIRTH MONTH <u>August</u> DAY <u>28</u> YEAR <u>1900</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>West Indies</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>82</u> YRS.	
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>DEATON MEDICAL CENTER</u>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Maryland</u>		13b. COUNTY <u>---</u>		13c. CITY OR TOWN <u>Baltimore</u>	
14. FATHER'S NAME FIRST <u>Thomas</u> MIDDLE <u>---</u> LAST <u>Joseph</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Mary</u> MIDDLE <u>---</u> LAST <u>Edwards</u>		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Teacher</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>062-30-6252</u>		17. INFORMANT <u>Dr. George Phillips</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>4140</u> IMMEDIATE CAUSE (a) <u>Heart Disease, arteriosclerotic</u>		DUE TO, OR AS A CONSEQUENCE OF (b) _____		DUE TO, OR AS A CONSEQUENCE OF (c) _____	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CAS</u>		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (this hospital) attended the deceased from <u>3/6/82</u> to <u>9/5/82</u> , that (we) last saw the deceased alive on <u>9/5/82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE <u>J.R. Gladue</u> DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>9/6/82</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. R. Gladue M.D.</u>	
22e. ADDRESS <u>Deaton Medical Center, Baltimore, Md.</u>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Sept. 82</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Anglican Church Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Scarbrough</u> <u>Tabago</u>		24. FUNERAL DIRECTOR <u>Witzke P.A.</u>	
25a. DATE REC'D. BY REGISTRAR <u>SEP 8 1982</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Givish</u>		25c. DATE OF DEATH <u>SEP 5 1982</u>	



United Methodist Church, Catonsville, Md.
Contact: Robert Smith, 888-2-2000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 2 2 3 3 8 1 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Phillips Leona				2a. DATE OF DEATH MONTH DAY YEAR 9-13-82		2b. HOUR 6A ^M	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 10 15 1916		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7b. HOUR 6A ^M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Dahlgren, SC.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John L. Denton Medical Ctr				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Charlie Jackson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Pierce		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No					
16b. SOCIAL SECURITY NO.		17. INFORMANT Early T. Jackson				ADDRESS 3308 Walbrook Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of intestine c liver metastases 1590 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) S/P lymphocytic meningitis (c) S/P CVA c/tt hemiparesis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Aug 25 1982 to Sept 13 1982, that (I) (we) last saw the deceased alive on Sept 13 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Julian W. Reed M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/13/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JULIAN W. REED M.D.		22e. ADDRESS 611 S. CHAS. ST. BALTO. MD. 21230							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/13/82		23c. NAME OF CEMETERY OR CREMATORY Hoodfield		23d. LOCATION CITY OR TOWN COUNTY STATE DARLINGTON S.C.			
24. FUNERAL DIRECTOR (NAME) William C. Brown		ADDRESS 1206 W. North Ave.		25a. DATE REC'D. BY REGISTRAR SEP 21 1982		25b. REGISTRAR'S SIGNATURE J. C. Carver			

MEDICAL CERTIFICATION

April 22, 1892

Dear Mr. [illegible]

I have just received your letter of the 21st inst.

and am glad to hear that you are well.

I am writing you a few lines to let you know that I am still in the city.

I am very busy at present, but I will try to find time to write you again.

I am, dear Mr. [illegible], very respectfully,
Your obedient servant,
[illegible]

P.S. I have just received your letter of the 21st inst.

and am glad to hear that you are well.

I am writing you a few lines to let you know that I am still in the city.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2

2 3 3 8 2

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
HARRY L. PIERCE		09 01 82		11 20 P M			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.	
Male	White	March 1, 1904	78 YRS.				
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Penna	BALTIMORE	THE UNION MEMORIAL HOSPITAL	Retired Carpenter		BALTIMORE CITY MD		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
Maryland		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	2705 Goodwood Rd			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
Frederick S. Pierce		Mary Stanert					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMATION			
Yes		U.S. Navy		Rt. # 2 Box 328 Mr Harry F Pierce Lovettsville, Va			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19. IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4100		Myocardial infarction					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		(c)			
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				CITY OR TOWN COUNTY STATE			
22a. I certify that (I (this hospital) attended the deceased from 9 1 19 82, to 9 7 19 82, that (we) last saw the deceased alive on 9 1 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
J. H. Copeland MD		MD		9 28 82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
J. H. COPELAND M.D.		201 EAST UNIVERSITY PARKWAY 21218					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		9/4/82		Parkwood		Baltimore, Maryland	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Leonard J Ruck Inc. Baltimore, Maryland		SEP 2 1982		John J. Connel			

Page 18 of 10

11

WMD EMI

1997 NOV 16



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 3 8 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MAXINE		FIRST PIERCE		LAST		2a. DATE OF DEATH MONTH DAY YEAR Sept. 22, 1982			2b. HOUR 9:11 P.M.		
3. SEX Female		4. RACE Negroid		5. DATE OF BIRTH MONTH DAY YEAR Nov. 26 1918		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.			IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City, MD.					
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2732 E. Chase St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.				13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2732 E. Chase St.	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Wagstaff				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Villins							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-22-5634		17. INFORMANT ADDRESS JAMES WAGSTAFF 3645 Forest Garden Ave							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CANCER COLON, METASTATIC 1539 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 MONTH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION 7-20-82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CANCER COLON				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from 6-29 , 19 82 , to 9-17 , 19 82 , that (1) (we) lost saw the deceased alive on 9-17 , 19 82 , and that in my (1) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Carlton C. Greene MD				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-24-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CARLTON C. GREENE				22e. ADDRESS 1000 E. EAGER ST.							
23a. BURIAL, CREMATION, REMOVAL (SP) Burial		23b. DATE 9-27-82		23c. NAME OF CEMETERY OR CREMATORY Balto. Nat'l Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. MD.					
24. FUNERAL DIRECTOR NAME Calvin B. Scruggs				ADDRESS 1412 Preston St		25a. DATE REC'D. BY REGISTRAR SEP 24 1982		25b. REGISTRAR'S SIGNATURE John J. Canine			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

POST OFFICE BOX 1000

NEW YORK

NEW YORK



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 3 8 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MAUDE			FIRST PIERSON			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
3. SEX FEMALE			4. RACE BLACK			5. DATE OF BIRTH MONTH DAY YEAR 05-04-92			6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland			13b. COUNTY			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 2523 Quantico Avenue		
14. FATHER'S NAME FIRST MIDDLE LAST Horace Bladestone			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Jackson			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A			17. INFORMANT Leon Pierson		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) ATHEROSCLEROTIC CARDIO-VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) HYPOTHYROIDISM														
19a. DATE OF OPERATION AUG. 30, 1982			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED GASTROSTOMY (FEEDING)			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 8-10 , 19 82 , to 9-4 , 19 82 , that (I) (we) lost saw the deceased alive on 9-4 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Cesar Gamboa, M.D.			DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 9-4-82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CESAR GAMBOA, M.D.			22e. ADDRESS 96 N. CHARLES GEN. HOSPITAL											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9/8/82			23c. NAME OF CEMETERY OR CREMATORY Family Cem			23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Avenue			ADDRESS			25a. DATE REC'D. BY REGISTRAR SEP 8 1982			25b. REGISTRAR'S SIGNATURE <i>John J. [Signature]</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

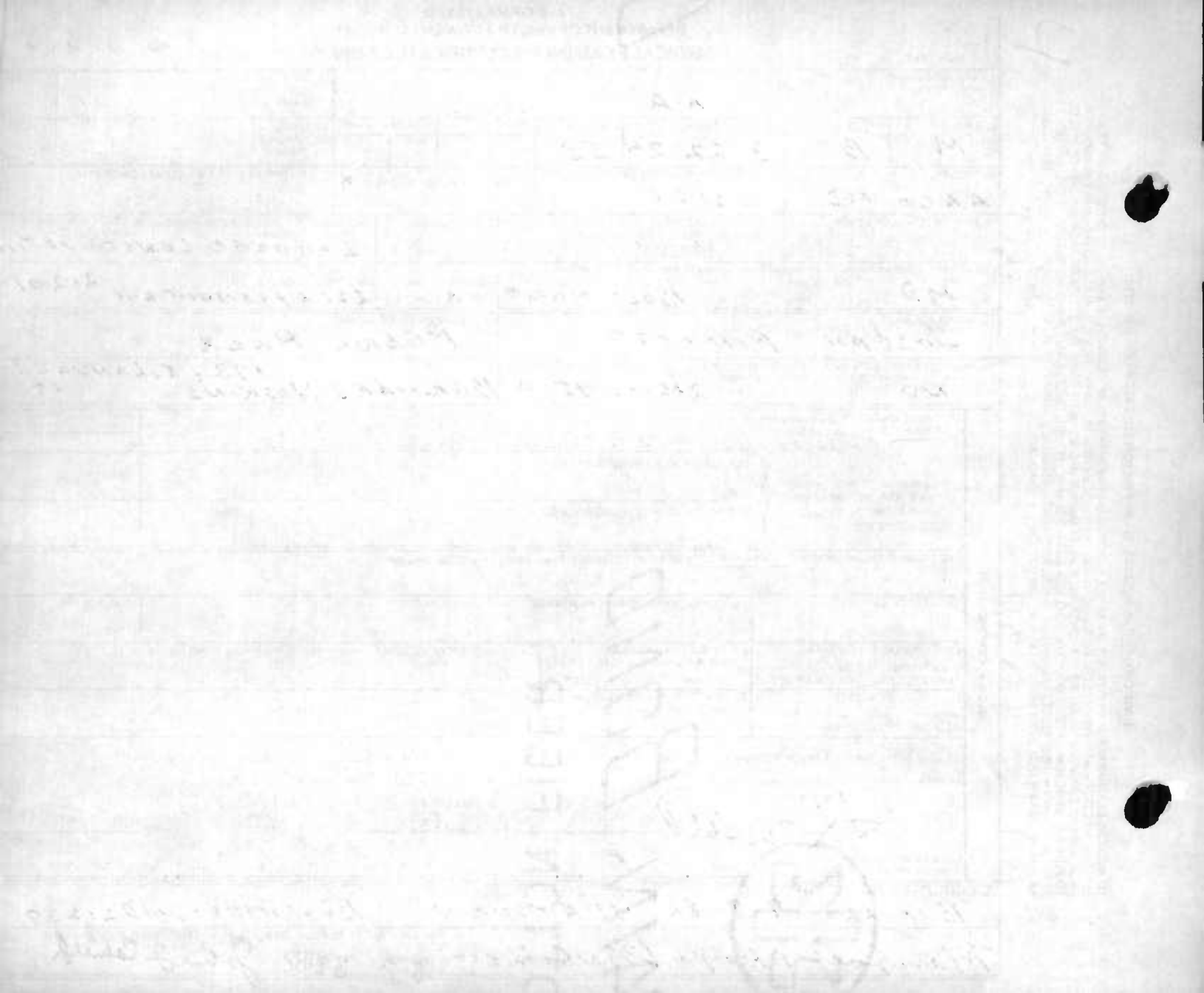
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 3 3 8 5 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Donald Pinacle				2a. DATE OF DEATH MONTH DAY YEAR 9 14 82		2b. HOUR M 14	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 8 7 33		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN. 49 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2624 Oswego Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Abraham Pinacle				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Tillery			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 215-28-2480		17. INFORMANT ADDRESS Maggielena Pinacle 2624 Oswego Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) PSYCHONCLOEMIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
I hereby certify that (I) (this hospital) attended the deceased from JAN 1982 to SEP 10 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard M. Hunt MD				DEGREE MD		22c. DATE SIGNED 9-15-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD M. HUNT MD				22e. ADDRESS 3319 BELLEVUE AVE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/18/82		23c. NAME OF CEMETERY OR CREMATORY Mount Calvary Cem Baltimore		23d. LOCATION CITY OR TOWN COUNTY STATE MD.	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H1101 E. North Avenue				25a. DATE REC'D. BY REGISTRAR SEP 17 1982			
				REGISTRAR'S SIGNATURE John J. Conish			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 2 2 3 3 8 6	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Joseph A Pinkett										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 9 DAY 3 YEAR 1982	
2. SEX M 4. RACE B 5. DATE OF BIRTH MONTH 3 DAY 22 YEAR 24 6. AGE (IN YEARS) 58 YRS. 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 7c. DATE PRONOUNCED DEAD MONTH 9 DAY 3 YEAR 1982 7d. HOUR 2:29											
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) AACO MD 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City 10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER CONSTRUCTION 12b. KIND OF BUSINESS OR INDUSTRY											
13a. STATE MD 13b. COUNTY BALTIMORE 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13d. STREET ADDRESS 221 N FREMONT AVE 21201											
14. FATHER'S NAME (FIRST MIDDLE LAST) JOSEPH PINKETT 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) PEARL PACE											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO 16b. SOCIAL SECURITY NO. 216-16-4510 17. INFORMANT ADDRESS 1734 E. LANVALE ST BERNARD HOSKINS											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 19c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21d. LOCATION CITY OR TOWN COUNTY STATE											
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE H R Guard TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 9/3/82											
EXAMINER'S NAME (TYPE OR PRINT) HORMEZ R. GUARD, M.D. ADDRESS 111 Penn Street, Balto., MD 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE 9-8-82 23c. NAME OF CEMETERY OR CREMATORY Mt ARBURN 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD 21230											
24. FUNERAL DIRECTOR NAME Marshall P Hoge ADDRESS 638 N G. 1 mo 25a. DATE REC'D. BY REGISTRAR SEP 3 1982 25b. REGISTRAR'S SIGNATURE John J. Connel											



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 3 8 7

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Clarence PINKNEY			2a. DATE OF DEATH MONTH DAY YEAR September 2, 1982		2b. HOUR 10:07^a	
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 11 - 18 - 10		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) G.A.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
13a. STATE Md			13b. COUNTY	13c. CITY OR TOWN BALTO		
14. FATHER'S NAME FIRST MIDDLE LAST Henry Pinkney			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lola Brown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - ? -		17. INFORMANT ADDRESS Bessie Pinkney 1821 Fulton Ave		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart disease (c) Colonic Ileus.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (X) this hospital attended the deceased from August 26 , 19 82 , to September 2 , 19 82 , that (X) (we) lost above (X) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Richard A. Lane M.D. 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Lane, M.D.				22c. DATE SIGNED 9/2/82		
22e. ADDRESS c/o Maryland General Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9-8-82		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. PK		
23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD		24. FUNERAL DIRECTOR NAME ADDRESS Vernon R. Bailey 1348 N. Calhoun St.				
25a. DATE REC'D. BY REGISTRAR'S SIGNATURE SEP 10 1982						

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of this.

Best interest

Myocardial Infarction

David J. Reardon

sent 10
corrected
copies 9/16/82

item 1 #G571 9/16/82 ph

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 3 8 8

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME FIRST MIDDLE LAST Raymond J. Pipino		9/4/82		6:55 PM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 21, 1930	6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) research analyst		12b. KIND OF BUSINESS OR INDUSTRY armament
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 65 Dunkirk Road
14. FATHER'S NAME FIRST MIDDLE LAST Walter S. Pipino, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen A. Eder			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212-28-1155		17. INFORMANT ADDRESS Mrs. Aneta Pipino 65 Dunkirk Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 2500 IMMEDIATE CAUSE (a) Diabetic enteropathy, DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/16/82, 1982, to 9/4, 1982, that (I) (we) last saw the deceased alive on 9/4/82, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Mark R. Stoeny MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/4/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark R. Stoeny		22e. ADDRESS Union Memorial Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation		23b. DATE 9/7/82		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Catonville Balto. Md		23e. DATE REC'D BY REGISTRAR SEP 7 1982			
24. FUNERAL DIRECTOR NAME Ambrose Funeral Home		ADDRESS 1328 Sulphur Spring Rd.		25a. DATE REC'D BY REGISTRAR SEP 7 1982	
25b. REGISTRAR'S SIGNATURE Joan J. Canine					

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MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 6 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified through the coroner's office.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 3 8 9
REG. NO.

1. DECEASED NAME (Type or Print) FIRST MIDDLE LAST SANTO P. PIRARO			2a. DATE OF DEATH MONTH DAY YEAR 9 18 82		2b. HOUR 9¹⁵ AM		
3 SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 1, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Produce Foreman	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Rosario Piraro				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Emmite			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-07-2389		17. INFORMANT ADDRESS Sarah M. Piraro 4703 Blueridge Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 3481 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) severe cerebral anoxia DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9-17 , 19 82 , to 9 18 , 19 82 that (I) (we) lost saw the deceased alive on 9-18-82 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. S. Janofsky MD				DEGREE MD		22c. DATE SIGNED 9-18-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. S. Janofsky				22e. ADDRESS Baltimore City Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sep 21 1982		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR SEP 20 1982		25b. REGISTRAR'S SIGNATURE John J. Conner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 3 3 9 0			
1. DECEASED NAME (TYPE OR PRINT) Emma A Pitzinger				2a. DATE OF DEATH MONTH DAY YEAR 09 21 82			
3. SEX Female.		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR 11 11 99		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Austria		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Balto. Gen. Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY —	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD. COUNTY A. Anundel CITY OR TOWN Linthicum		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1101 Furnace Rd. 21090			
14. FATHER'S NAME FIRST Albert MIDDLE Schetzzenburger LAST Emma		15. MOTHER'S MAIDEN NAME FIRST Emma MIDDLE unknown. LAST unknown.		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 275-22-2499	
17. INFORMANT Emma M. Arena		ADDRESS 9313 Joey Drive 21043		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) C.V.A. DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac arrhythmia DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardio Vascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Aspiration pneumonia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 9/19 , 19 82 , to 9/21 , 19 82 , that (1) (we) lost saw the deceased alive on Sept 21 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.							
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Alan N. Dennis		22c. DATE SIGNED 9/21/82		22d. ADDRESS 3001 S. Henover St. Balto. MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 09-25-82		23c. NAME OF CEMETERY OR CREMATORY GRACE EPIS. CH. CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE ELKRIDGE HOWARD MARYLAND	
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.		ADDRESS 4107 WILKENS AVE.		25a. DATE REC'D. BY REGISTRAR SEP 23 1982		25b. REGISTRAR'S SIGNATURE John J. Canine	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 2 2 3 3 9 1		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Henry J. Plunkert				2a. DATE OF DEATH MONTH DAY YEAR Sept. 12 1982				2b. HOUR A. M. 6:10	
3 SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Apr 2 1914		6. AGE (IN YEARS (LAST BIRTHDAY)) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Welsh Bldg Co	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE Md.		13b. COUNTY -		13c. CITY OR TOWN Balto.	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Plunkert				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Small		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. WW II 220 -22-6285		17. INFORMANT ADDRESS Jennie Plunkert (wife) same address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial infarct</i> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i> <i>yes</i>								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>no</i>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>10-4-74</i> 19____, to <i>6-30-82</i> 19____, that (I) (we) lost saw the deceased alive on <i>6-30-82</i> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>William L. Fearing</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9-14-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Wm. L. Fearing				22e. ADDRESS 3025 Belair Rd.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/15/82		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			
24. FUNERAL HOME Schmidke Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213				25a. DATE REC'D. BY REGISTRAR SEP 14 1982		25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>			



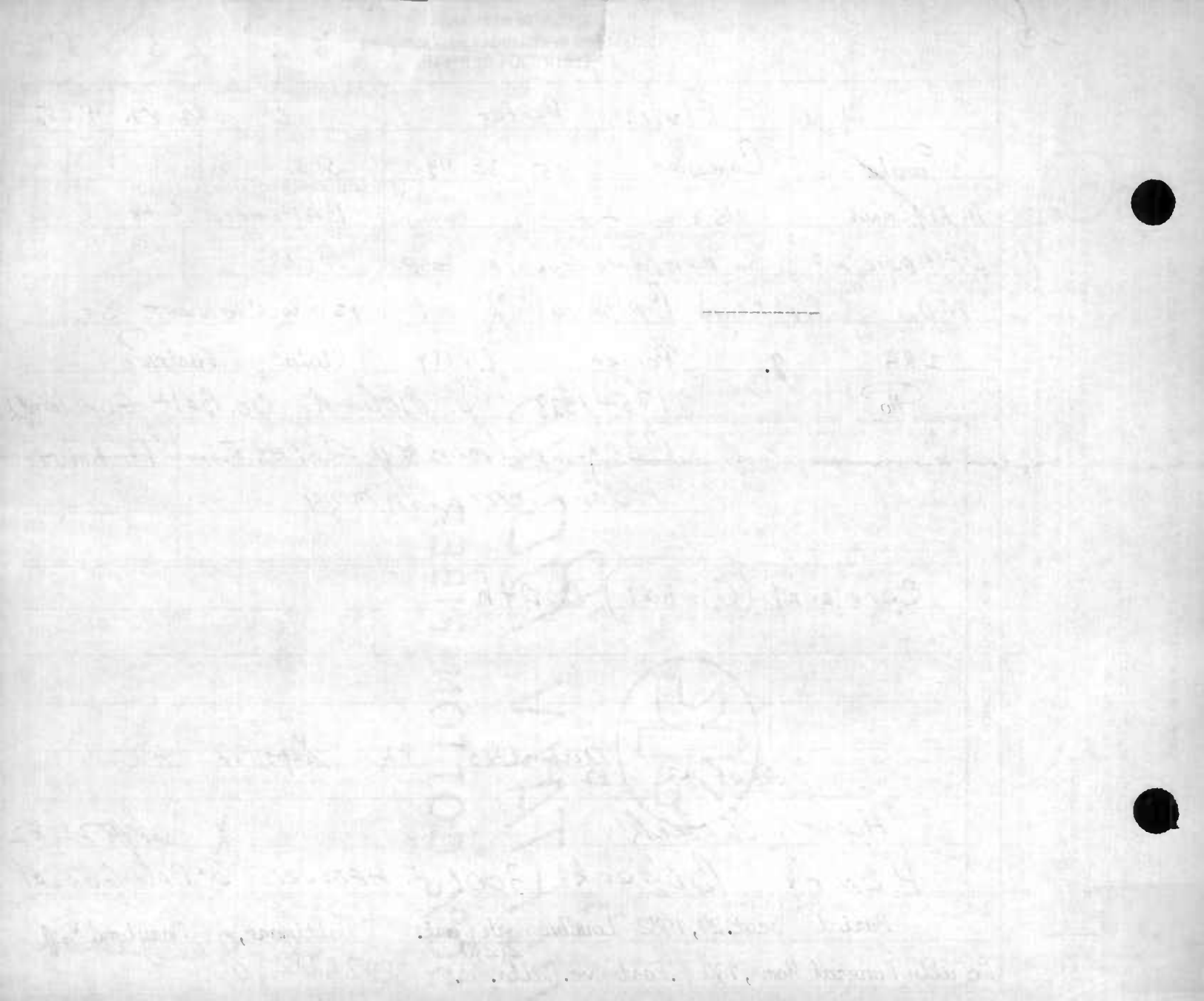
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department. Page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified if one.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 2 2 3 3 9 2							
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH				3a. HOUR			
FIRST MIDDLE LAST Hilda Elvira Porter		MONTH DAY YEAR 09 22 82		HOURS MIN. 4:05 PM					
2. SEX	4. RACE	5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
Female	Caucasian	MONTH DAY YEAR 05 30 99		83 YRS		MONTHS DAYS		HOURS MIN.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MADYLAND		USA				Baltimore City MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore, MD		So. Baltimore General Hosp.				NONE			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MD.		Baltimore		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		120 W. Clement St.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
FIRST MIDDLE LAST IRA J. Porter		FIRST MIDDLE LAST Lilly Viola Foster		217541328		H. Bobeck		So. Balt Gen Hosp	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR OTHER STATUS)		18b. SOCIAL SECURITY NO.		18c. DATE OF DEATH		18d. DATE OF DEATH		18e. DATE OF DEATH	
No		217541328		09 22 82		09 22 82		09 22 82	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		20. IMMEDIATE CAUSE (a)				20b. DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4275		Cardiopulmonary arrest				Heart arrhythmia		11 hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)				(c)			
Cerebral (Global) Death									
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
1982 09 22		Cerebral (Global) Death		Trauma		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		22c. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22d. LOCATION STREET CITY OR TOWN COUNTY STATE			
		P.M. 19							
22e. I certify that (I) (this hospital) attended the deceased from August 25, 1982, to Sept. 22, 1982, that (I) (we) last saw the deceased alive on Sept 22, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22f. SIGNATURE		22g. DATE SIGNED		22h. PHYSICIAN'S NAME (TYPE OR PRINT)		22i. ADDRESS	
		Henry Bobeck		Sept 22, 82		Henry Bobeck		3001 S. Hanover, S. Balt General	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		Sept. 24, 1982		Loudon Park Cemt.		Baltimore, Maryland			
24. FUNERAL DIRECTOR		24a. NAME		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR		24d. REGISTRAR'S SIGNATURE	
McClully Funeral Home, 130 E. Font Ave. Balto. Md.		21230		21230		SEP 24 1982		[Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer. The State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 2 3 3 9 3					
1. DECEASED NAME (TYPE OR PRINT) JANET (JANET)				LAST Posner (POSNER)				2a. DATE OF DEATH MONTH DAY YEAR 9 (September) 19 82				2b. HOUR 10 ⁰⁰ P.M.	
3. SEX Female		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 5 1 31		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. <input checked="" type="checkbox"/> XXX <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.							
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE				12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
13a. STATE MARYLAND				13b. COUNTY BALTO.		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XX		13e. STREET ADDRESS 3677 FOREST HILL RD. #21207			
14. FATHER'S NAME FIRST MIDDLE LAST MAX MEYERS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATIE FRIEDMAN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 214-26-6354		17. INFORMANT MR. DONALD POSNER							
						3677 FOREST HILL RD. BALTO., MD 21207							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) pulmonary emboli DUE TO, OR AS A CONSEQUENCE OF (b) metastatic carcinoma of breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks Common													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death													
22b. SIGNATURE Richard A. Berg				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/15/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard A. Berg				22e. ADDRESS Suite 400, 711 W 40th St, Balt 21211									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE SEPT. 21, 1982		23c. NAME OF CEMETERY OR CREMATORY MIKRO KODESH				23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215								25a. DATE REC'D. BY REGISTRAR SEP 23 1982		25b. REGISTRAR'S SIGNATURE John J. Connel			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 2 3 3 9 4	
1. DECEASED NAME (TYPE OR PRINT) JOSEPH E. POULSON						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9-11-82		2b. HOUR AM			
3. SEX Male	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR 5/27/49	6. AGE (IN YEARS) (LAST BIRTHDAY) 33 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 9-11-82		2d. HOUR 5:37 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY ----			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY ----		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3844 Quarry Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST Walter L.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Geneva V.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----		17. INFORMANT ADDRESS Mother						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 0389 IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Margarita A. Korell			TITLE (SPECIFY) Assistant				DATE SIGNED 9-12-82				
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.			ADDRESS 111 Penn Street								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/15/82		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.				
24. FUNERAL DIRECTOR NAME ADDRESS Paul E. Chenoweth 3rd. 3617 Chesnut Ave.						25a. DATE REC'D. BY REGISTRAR SEP 15 1982		25b. REGISTRAR'S SIGNATURE John J. Conner			



NOTICE
1943

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 3 3 9 5													
1. FOR STATE REGISTRAR		REG. NO.																					
1. DECEASED NAME (TYPE OR PRINT)		FIRST CHARLES		MIDDLE F.		LAST POWELL		2a. DATE OF DEATH		MONTH 9		DAY 9		YEAR 82		2b. HOUR 45		MIN 6 A.M.					
3. SEX Male		4. RACE Black		5. DATE OF BIRTH		MONTH 7		DAY 16		YEAR 95		6. AGE (IN YEARS LAST BIRTHDAY)		87 YRS.		7. UNDER 1 YEAR		8. UNDER 24 HRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.																	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pimlico Manor										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian		12b. KIND OF BUSINESS OR INDUSTRY Apt. Bldg.									
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. COUNTY Maryland		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2600 Oakley Avenue Baltimore, Maryland 21215													
14. FATHER'S NAME				FIRST Clarence		MIDDLE H.		LAST Powell		15. MOTHER'S MAIDEN NAME				FIRST Susie		MIDDLE Foreman		LAST Foreman					
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 1		17. INFORMANT Baltimore, ADDRESS Maryland 21215 Mrs. Alta Wright 2600 Oakley Avenue																	
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic vascular changes in atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Heart																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 1 yr years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that (I) (this hospital) attended the deceased from 8-12-19-77, to 8-9-19-82, that (I) (we) lost saw the deceased alive on 8-9-19-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE Dr. L.A. Kochman																DEGREE				22c. DATE SIGNED 8-9-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. L.A. Kochman																22e. ADDRESS 10 Stonohenge Circle - Baltimore Md 21208							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9/13/82				23c. NAME OF CEMETERY OR CREMATORY Crownsville Vet. Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co., Md.											
24. FUNERAL DIRECTOR NAME BALTIMORE MARYLAND ADDRESS 21216 HERBERT E. NUTTER FUNERAL HOME 3035 W. NORTH AVENUE																25. DATE REC'D. BY REGISTRAR SEP 9 1982				25. REGISTRAR'S SIGNATURE John J. Calver			

BP

DHMH-16 25M
(VRA 15, 4) 1/79

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 3 9 6

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FLETIE MIDDLE POYNER		2a. DATE OF DEATH MONTH SEPT DAY 09 YEAR 17 82		2b. HOUR 11 A.M.	
3 SEX FEMALE		4 RACE NEGRO		5 DATE OF BIRTH MONTH DEC DAY 9 YEAR 1906	
6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) FLORIDA		7b. CITIZEN OF WHAT COUNTRY? USA		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION BALTIMORE CITY HOSPITALS		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BEAUTICIAN		12b. KIND OF BUSINESS OR INDUSTRY SELF		21217	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS 1917 N. PAYSON ST.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 262-22-2723A		17 INFORMANT ADDRESS 21217	
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Arrest 0389 DUE TO, OR AS A CONSEQUENCE OF Sepsis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF Chronic Debulatative (c) Chronic Debulatative					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b): (C) CVA, Diabetes, Hypertension, Pressure Sores.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from July 14 19 82 to Sept 17 19 82 , that (I) (we) last saw the deceased Sept 17 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) viewed the body after death.		22b. SIGNATURE Vikas Saini DEGREE MD	
22c. DATE SIGNED 9-17-82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Vikas Saini		22e. ADDRESS 4940 Eastern Ave Balt.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 09/24/82		23c. NAME OF CEMETERY OR CREMATORY MT ZION CEMETERY	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		24. FUNERAL DIRECTOR NAME MARSHALL W JONES, JR ADDRESS 4101 EDMONDSON AVE		25a. DATE REC'D BY REGISTRAR SEP 23 1982	
25b. REGISTRAR'S SIGNATURE James J. Connelley					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 3 3 9 7	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST DEWEY		MIDDLE Berton		LAST PRICE		2a. DATE OF DEATH MONTH DAY YEAR 9 13 82		2b. HOUR 1:35 P.M.	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 10 12 98		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.					
10. CITY OR TOWN OF DEATH BALT, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALT. GEN HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Iron Worker		12b. KIND OF BUSINESS OR INDUSTRY Construction			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY ---		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1113 East Patapsco Ave. 21225			
14. FATHER'S NAME FIRST MIDDLE LAST Thomas George Price		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella --- Gibson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 209-07-2586		17. INFORMANT Amelia Price		ADDRESS Sameas #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 END STAGE CARDIAC DISEASE DUE TO, OR AS A CONSEQUENCE OF (b) MULTIPLE INFARCTIONS DUE TO, OR AS A CONSEQUENCE OF (c) SEVERE ASLVO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Renal Failure, Liver Failure, GI Bleeding											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 9/12/82, 1982, to 9/13, 1982, that (I) (we) last saw the deceased alive on 9/13, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE M. McCarthy		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 9/13/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. MCCARTHY		22e. ADDRESS 3001 S. Hanover ST., Balt. Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/16/1982		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A. A. Co., Md.					
24. FUNERAL DIRECTOR NAME McGully Funeral Homes		24b. ADDRESS 237 E. Patapsco Ave., Balto., Md., 21225		25a. DATE REC'D. BY REGISTRAR SEP 15 1982		25b. REGISTRAR'S SIGNATURE John J. Connel					

16

NAME - Mr. J. H. Smith

COMPANY - The Smith Company

ADDRESS - 123 Main Street

CITY - New York

STATE - New York

ZIP - 10001

DATE - 10/1/54

TO - Mr. J. H. Smith

FROM - Mr. J. H. Smith

SUBJECT - 100-100000

RE - 100-100000

100-100000

100-100000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 3 3 9 8 REG. NO.			
1. FOR STATE REGISTRAR		1. DECEASED (TYPE OR PRINT): FIRST MIDDLE LAST Panayotis - Pristouris				2a. DATE OF DEATH MONTH DAY YEAR September 10, 1982				2b. HOUR 7:50 P.M.			
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 25, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece		7b. CITIZEN OF WHAT COUNTRY? Greece		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Merchant		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Greece		13b. CITY OR TOWN Kifissia Attiki		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS Filadelfeos 60							
14. FATHER'S NAME FIRST MIDDLE LAST Hristos - Pristouris				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria - Stathopoulos									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				16b. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS Mrs. Angelika P. Pristouris same							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4476 Intra-abdominal abscess + sepsis DUE TO, OR AS A CONSEQUENCE OF, Acute bowel infarction on palpation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Cutaneous (c) Cutaneous										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Mary Betty Stevens M.D.				22c. DATE SIGNED 9/10/82									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARY BETTY STEVENS				22e. ADDRESS Good Samaritan Hospital, Baltimore, Md. 21239									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Sept. 17, 1982		23c. NAME OF CEMETERY OR CREMATORY Sparta Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Sparta Greece					
24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. Baltimore, Maryland USA						25a. DATE REC'D. BY REGISTRAR SEP 14 1982		25b. REGISTRAR'S SIGNATURE John J. Carver					

BP

September 10, 1952

Baltimore City

Paraphrase of Testimony

Examination

Greece

Good Samaritan Hospital

Greece

Examination

Greece

Examination

no

none

Examination

Examination

Tabular statement of facts
Hate based upon a prejudice
(Notes)

9/10/52

X

Mary Betty Stevens M.D.

MARY BETTY STEVENS

Good Samaritan Hospital, Baltimore, Md.

Stevens

Examination

Oct. 17, 1952 - Examinations

(Notes)

SEP 10 1952

Twentieth Century-Fox Inc., Hollywood, California

RELEASED AS NON MED BY DR GUARD OF THE
MEDICAL EXAMINER'S OFFICE

TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 076 292 133 A 9			
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT)			
FIRST MIDDLE LAST				2. DATE OF DEATH (MONTH DAY YEAR) HOUR			
VIRGINIA (nmn) PROGAR				SEPTEMBER 17, 1982 01:30 PM			
3. SEX		4. RACE		5. DATE OF BIRTH (MONTH DAY YEAR)		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		Jan. 12, 1918		64 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Kentucky		USA				BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		THE JOHNS HOPKINS HOSPITAL		Housewife		Own Home	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		A.A.		Glen Burnie		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME (FIRST MIDDLE LAST)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Casper Biel		Mary Adaline Wachter		No		406/03/8851	
17. INFORMANT (Husband)		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			
Mr. Henry E. Progar Sr.		Same as # 13		IMMEDIATE CAUSE (a) Cardiac failure			
				4149 DUE TO, OR AS A CONSEQUENCE OF (b) coronary artery disease		2 years	
				DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.							
Coronary artery bypass							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
9-17-82		Coronary artery disease		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF FURTHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY (HOUR A.M. MONTH DAY YEAR)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)			
22a. I certify that (I) (this hospital) attended the deceased from 9/15, 1982, to 9/17, 1982, that (I) (we) last saw the deceased alive on 9/17, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
Kenneth W Sharp MD						9-17-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
KENNETH W SHARP		Johns Hopkins Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN COUNTY STATE)	
Burial		20 Sept. 82		Glen Haven Mem. Pk.		Glen Burnie, A.A., MD.	
24. FUNERAL DIRECTOR (NAME)		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
G. Easter		Glen Burnie, MD.		SEP 21 1982		John J. Conner	

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 01-10-2001 BY 60322 UCBAW/BJS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B, temporary injury, or other traumatic event, the medical examiner must be notified to be called to the scene.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 3 4 0 0 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Bessie PROSER					2a. DATE OF DEATH MONTH DAY YEAR 9 2 82					2b. HOUR 9 A.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 22 1904		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.							
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINDALE HEBREW HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY		12b. KIND OF BUSINESS OR INDUSTRY BD. OF EDUCATION					
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4001 CLARKS LA., APT. 306 21215					
14. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM WISE					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SONIA KWATIR KWATIR								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 068-32-2378		17. INFORMANT ADDRESS MRS. SONIA KINZLER 25 HOPPER ST. HILLSDALE, NJ 07642									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CA lung, undifferentiated 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MAY 1981			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes mellitus													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 08-06 19 82 to 09-02 19 82 , that (I) (we) lost saw the deceased alive on 09-02 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE [Signature]			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/2/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. ZAW-WIN, MD			22e. ADDRESS Levin Dale Hebrew Ger. CH Balto 21215										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE SEPT. 3, 1982		23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH			23d. LOCATION BALTIMORE COUNTY MARYLAND						
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR SEP 8 1982		25b. REGISTRAR'S SIGNATURE [Signature]					

NOTED FOR

NOTED FOR

SEP 8 1933

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 3 4 0 1 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
Clementine Ranson				9 17 82			
3 SEX				4 RACE			
Female				Black			
5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)			
12 25 24				58 YRS.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b CITIZEN OF WHAT COUNTRY?			
Virginia				USA			
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			
Baltimore				2500 Winchester Street			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. INSIDE CITY LIMITS?			
13a. STATE				13b. INSIDE CITY LIMITS?			
Maryland				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
Turner				Ethel			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)				16b. SOCIAL SECURITY NO.			
NO				224-26-0772			
17. INFORMANT				ADDRESS			
A Ifonso Jones				2500 Winchester St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) GI Bleed / Circulatory Collapse				2-3 hrs			
DUE TO, OR AS A CONSEQUENCE OF:							
(b) Metastatic Cervical Cancer				1 yr			
DUE TO, OR AS A CONSEQUENCE OF:							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from Sept. 9, 1982, to Sept. 17, 1982, that (we) last saw the deceased alive on Sept. 17, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Alvin R. Sills, MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		9/20/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Alvin R. Sills, MD				University Hosp. Balto. Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL		9/22/82		Holly Hill Cem		Whitemarsh Md.	
24. FUNERAL DIRECTOR				25a. DATE REC'D BY REGISTRAR			
NAME ADDRESS				25b. REGISTRAR'S SIGNATURE			
Wm. C. march F/H 1101 E. north Avenue				SEP 21 1982			



Handwritten text, possibly a date or reference number, located in the middle left section of the page.

Handwritten text at the bottom left corner of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 3 4 0 2	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) MILBURN D Rawlings					2a. DATE OF DEATH MONTH DAY YEAR 9/4/82			2b. HOUR 2:30 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 19, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sheet Metal Mech.		12b. KIND OF BUSINESS OR INDUSTRY Martin's			
13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN Parkville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Holdworth B. Rawlings					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mollie Scrivener						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 216-09-5950A		17. INFORMANT ADDRESS Ruth A. Rawlings, 8006 Harford Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 0389 IMMEDIATE CAUSE (a) myocardial Sepsis DUE TO, OR AS A CONSEQUENCE OF: (b) infected Partial hip arthroplasty DUE TO, OR AS A CONSEQUENCE OF: (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (d) Congestive heart failure, secondary											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 9-1-82 19 to 9-4-82 1982, that (1) (we) lost saw the deceased alive on 9-4-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE [Signature]					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 9-4-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RD ARORA					22e. ADDRESS 5AH, Baltimore						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 7, 1982		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Balto., Md.				
24. FUNERAL HOME OR ADDRESS ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Balto., Md. 21214					25a. DATE REC'D. BY REGISTRAR SEP 7 1982		25b. REGISTRAR'S SIGNATURE [Signature]				

RECEIVED
FEB 19 1957

Mr. J. Edgar Hoover
Director
Federal Bureau of Investigation
Washington, D. C.

Dear Sir:

Enclosed for you are two copies of a letterhead memorandum (LHM) dated and captioned as above. The LHM was prepared by the [redacted] and is being furnished to you for your information and guidance.

Very truly yours,
[Signature]
Special Agent in Charge

Enclosure

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 2 3 4 0 3			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EARL STEWART READ				2a. DATE OF DEATH MONTH DAY YEAR 9 24 82		2b. HOUR 4:15 A M	
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 25 16		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS 65 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY AUTOMOBILE	
13a. STATE MARYLAND				13b. CITY OR TOWN BALTIMORE		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM READ				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NAOMI WADE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 212-05-2468		17. INFORMANT ADDRESS JOHN C. READ 8049 MAIN STREET ELICOTT CITY, MD. 21043			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) Resp. failure DUE TO, OR AS A CONSEQUENCE OF (b) aspiration pneumonia (Recurrent) DUE TO, OR AS A CONSEQUENCE OF (c) debilitation, cerebral anoxia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Post-CPR, CRA, malnourishment, Post resp. failure, Anemia, muscle atrophy							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1st Sept 19 82 to Sept. 24 19 82 , that (I) (we) lost the deceased alive on Sept 24 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Purnashottam mitra				DEGREE MD		22c. DATE SIGNED 9/24/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PURUSHOTAM MITRA				22e. ADDRESS ST. AGNES HOSPITAL, 900 S. CATON AVE.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 09-28-82		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229				25a. DATE REC'D. BY REGISTRAR SEP 27 1982		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>	

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [illegible]
RE: [illegible]
DATE: [illegible]

[illegible text block]

[illegible text block]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 2 3 4 0 4	
1. DECEASED NAME (TYPE OR PRINT) James Reed						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 9 23 19 82		2b. HOUR M			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11 6 27	6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 23 19 82		2d. HOUR 2:P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.			13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4 N. Central Ave.		
14. FATHER'S NAME FIRST MIDDLE LAST Jackson Reed				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fern Radcliff							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) Korean War		16b. SOCIAL SECURITY NO. 232-44-1575		17. INFORMANT ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Hormez R. Guard			TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER				DATE SIGNED 9/24/82				
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.			ADDRESS 111 Penn Street, Balto., MD 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 10/5/82		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME ADDRESS Anatomy Board Balto., Md.					25a. DATE REC'D. BY REGISTRAR OCT 7 1982		25b. REGISTRAR'S SIGNATURE John J. Canine				

10-10-10

10-10-10



10-10-10

10-10-10

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR										3 2 2 3 4 0 5									
1. DECEASED NAME (TYPE OR PRINT) William Reeley										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 9 17 19 82									
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov, 25, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 9 17 19 82		2d. HOUR 9:27 AM					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.							
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3009 E. Monument Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) salesman				12b. KIND OF BUSINESS OR INDUSTRY men's clothing							
13a. STATE Md				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3009 E. Monument Street									
14. FATHER'S NAME FIRST MIDDLE LAST John Reeley						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Wheeler													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-09-7989		17. INFORMANT ADDRESS Ellen Thompson Laurel, Maryland													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE Hormez R. Guard				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 9/17/82							
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.				ADDRESS 111 Penn Street, Balto., MD 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Sept. 21, 1982		23c. NAME OF CEMETERY OR CREMATORY Emmanuel Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Sacksville, Md									
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home, Laurel, Md				DATE RECD. BY REGISTRAR SEP 28 1982															



12-1-58

MEMORANDUM FOR THE RECORD

SUBJECT: [Illegible]

DATE: [Illegible]

BY: [Illegible]

1. [Illegible]

2. [Illegible]

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99. [Illegible]

100. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of this.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 3 4 0 6 REG. NO.			
1. FOR - STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) James Randolph Reeves						2a. DATE OF DEATH MONTH DAY YEAR September 24, 1982				2b. HOUR 2:25 AM			
1. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 6, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. UNDER 1 YEAR MONTHS DAYS		7. UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter (ret)		12b. KIND OF BUSINESS OR INDUSTRY Johns Hopkins					
13a. STATE Maryland		13b. COUNTY A.A. Co.		13c. CITY OR TOWN Linthicum		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS (21090) Maint. 813 Andover Road					
14. FATHER'S NAME FIRST MIDDLE LAST James L. Reeves				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eulala Ryan									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		21. INFORMANT (Wife) Mrs. Lavinia A. Reeves		ADDRESS same as # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4960 IMMEDIATE CAUSE (a) Cardio Pulmonary arrest.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										DUE TO, OR AS A CONSEQUENCE OF (b) COPD.			
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pneumonia													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (this hospital) attended the deceased from 9/11/82 to 9/24/82, that (we) last saw the deceased alive on 9/23/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Burnie				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 9/24/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B-K. SINHA				22e. ADDRESS ST. AGNES HOSP. BALTO.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 24 Sept. 82		23c. NAME OF CEMETERY OR CREMATORY Security Proc. Inc.		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Balto., MD.							
24. FUNERAL DIRECTOR NAME G. Easton		ADDRESS Singleton Funeral Home		25a. DATE REC'D. BY REGISTRAR SEP 28 1982		25b. REGISTRAR'S SIGNATURE John J. Cahill							



UNITED STATES

NAVY

DEPARTMENT

POST OFFICE

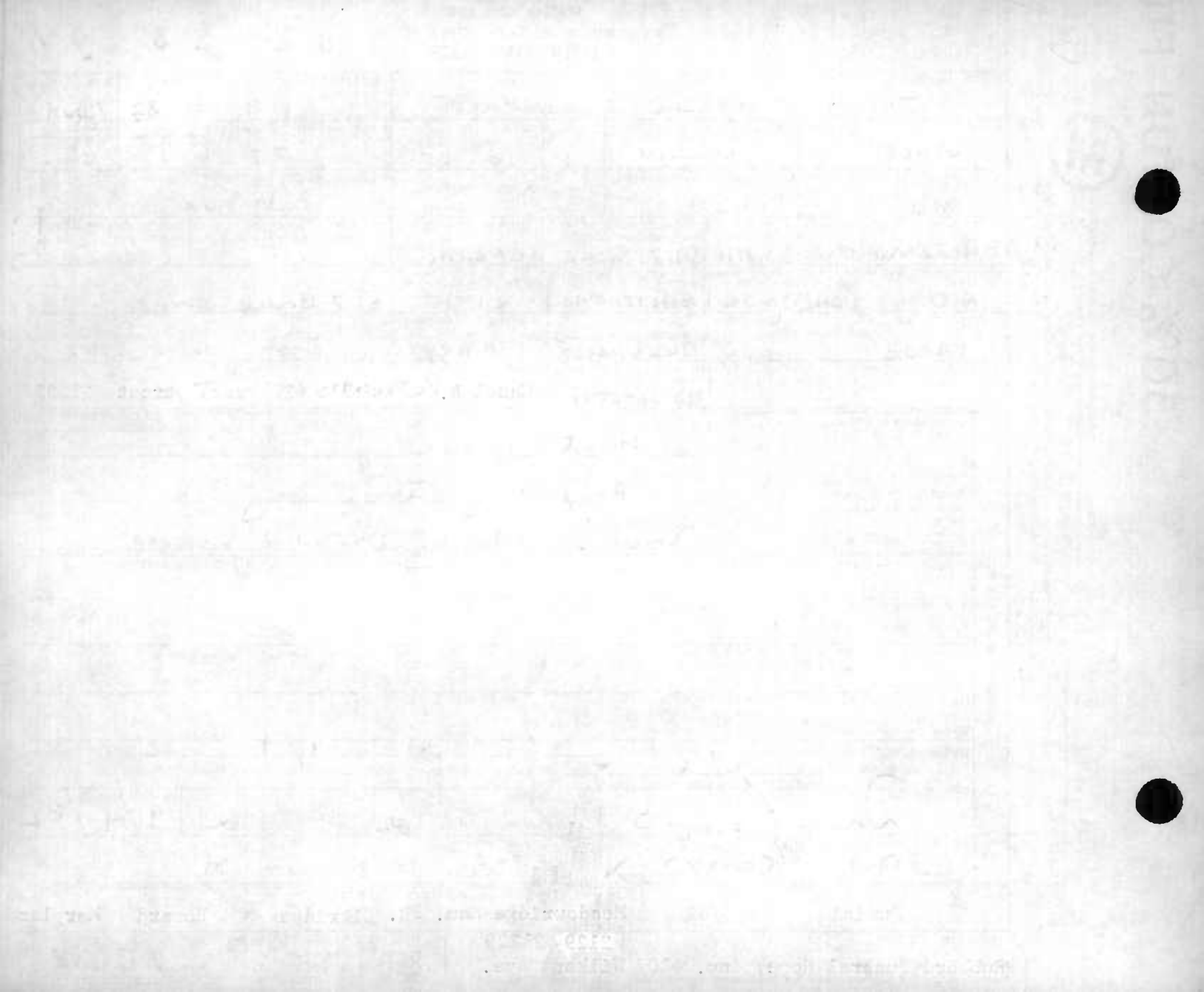
NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 2 3 4 0 7	
1. DECEASED NAME (TYPE OR PRINT) JACOB HAROLD REINHARDT					2a. DATE OF DEATH MONTH DAY YEAR 9 4 82			2b. HOUR 7:00 A.M.			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 10 05		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GENERAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Buyer		12b. KIND OF BUSINESS OR INDUSTRY WESTINGHOUSE			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. CITY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 627 Bruce Street			
14. FATHER'S NAME FIRST MIDDLE LAST JACOB REINHARDT					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY HUBB LITZ						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-32-5011		17. INFORMANT ADDRESS Hazel B. Reinhardt 627 Bruce Street 21225							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Pulmonary Obstructive Disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 8/15 , 19 82 , to 9/7 , 19 82 , that (I) (we) last saw the deceased alive on 9/7 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dan Campo			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/4/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAN CAMPO					22e. ADDRESS 3001 S. Hanover St.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/8/82		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.			23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Maryland			
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.					24b. ADDRESS 21229		25a. DATE REC'D. BY REGISTRAR SEP 7 1982		25b. REGISTRAR'S SIGNATURE John J. Caniff		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 13e 9/20/82 dad

FOR
1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8 2 2 3 4 0 8

1. DECEASED NAME (TYPE OR PRINT) G. GORGE REISTER		2a. DATE OF DEATH MONTH 09 DAY 11 YEAR 82		2b. HOUR M
3. SEX MALE	4. RACE NEGRO	5. DATE OF BIRTH MONTH 05 DAY 18 YEAR 1888		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JEWISH CONVALESCENT CTZ - PAUMotu		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST John MIDDLE Reister LAST Parker		15. MOTHER'S MAIDEN NAME FIRST Ann MIDDLE Jewish LAST Convalescent n. H.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-12-9837		17. INFORMANT ADDRESS Veronica Stovall 722 Nome St.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4292 ASCVD IMMEDIATE CAUSE (a) ASCVD DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 7-18 , 19 80 , to 9-11 , 19 82 , that X (we) lost saw the deceased alive on 9-11 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Arthur N. Lebron MD		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-12-82
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 3640 FORDS LANE 21245		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 9/15/82	23c. NAME OF CEMETERY OR CREMATORY King Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Avenue		25a. DATE REC'D. BY REGISTRAR SEP 15 1982		
		25b. REGISTRAR'S SIGNATURE John J. Lewis		

1000 1000 1000



Handwritten signature or text at the bottom left corner.

300 71 182 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR			8 2 2 3 4 0 9 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) MARIE E REITER			2a. DATE OF DEATH 9 / 26 / 1982			2b. HOUR 7:15 P.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH Jan. 28, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Adamstown, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY ---		
13a. STATE Md.			13b. COUNTY Baltimore			13c. CITY OR TOWN Catonsville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 5721 Edmondson Avenue			14. FATHER'S NAME (FIRST MIDDLE LAST) John H. Kessler			15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Elizabeth A. Greene				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-44-8489			17. INFORMANT ADDRESS Ellicott City, Md. 21043. Frank T. Reiter, Jr.-3106 Old Fence				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart disease</u>									18a. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Rd.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cirrhosis of liver due to congestive heart failure.</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (this hospital) attended the deceased from <u>9/25/1982</u> to <u>9/26/1982</u> , that (we) last saw the deceased alive on <u>9/26/1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>B. K. Sinha</u>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/26/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. K. SINHA			22e. ADDRESS ST- AGNES HOSPITAL, BALTIMORE MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/29/82		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.			
24. FUNERAL DIRECTOR NAME Sterling Funeral Estate			25. DATE RECEIVED BY REGISTRAR SEP 29 1982			26. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 4 1 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
ELIZABETH		REULING		09-24-82		7:35pm	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female	White	April 5, 1892		90			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Balto., Md.	U. S. A.			Baltimore City, MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	Church Hospital Corp.		Housewife		----		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
Md.		Baltimore	Arbutus			1234 Maiden Choice Lane	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
John Hackman		Elizabeth Westinghouse					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			
No		212-07-9626D		Catonsville, Md. 21228.			
				Raymond E. Reuling-1206 Tugwell Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from XXXX 09-08 19 82 to XXXX 09-24 19 82 and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Dr. Walker Impagliatelli		22c. DATE SIGNED 9/24/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
DR. WALKER IMPAGLIATELLI M. D.		CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MARYLAND 21231					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial	9/27/82	New Cathedral Cemetery		Baltimore, Md.			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Sterling Funeral Estate		SEP 28 1982		John G. Smith			
736 Edmondson Ave.		Catonsville, Md. 21228					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR			
Charles Henry Reuwer Jr.						9 26 1982						M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR	
Male		White		March 18, 1943		39 YRS.		MONTHS DAYS		HOURS MIN		9 27 1982		8:08 A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland				USA								Baltimore City, MD			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore				216 Monument Street				Laborer							
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland						Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		216 Monument St.					
14. FATHER'S NAME								15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST								FIRST MIDDLE LAST							
Charles Henry Reuwer								Gladys Brown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT							
(YES, NO, OR UNKNOWN)				(IF YES, GIVE WAR OR DATES)				ADDRESS							
No								3318 Ryerson Circle Alma Magersupp Baltimore, Md. 21227							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>Strangulation</u>															
9630															
DUE TO, OR AS A CONSEQUENCE OF															
(b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY (EST.)				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				HOUR A.M. MONTH DAY YEAR				subject was strangled							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				Home				STREET CITY OR TOWN COUNTY STATE							
								216 Monument Street, Baltimore, Maryland							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED							
<i>Dennis F. Smyth</i>				M.D. Assistant				MEDICAL EXAMINER				9-27-82			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Dennis F. Smyth, M.D.				111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
Burial				Sept. 30, 1982		Eastview				Baltimore City, Maryland					
24. FUNERAL DIRECTOR				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
NAME				6500 York Rd.				OCT 4 1982				<i>Jan E. Conner</i>			
Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212															

1101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the Division of Vital Records with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81
(VRA 15, 4)

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 2 3 4 1 2 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Riley M Rhodus		2a. DATE OF DEATH MONTH DAY YEAR 9-2-82	
3. SEX Male		RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7-23-1908	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 74 YRS.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deaton Medical Center		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist-Retired Natl. Brewery		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Balto.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Rhodus		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Moon		13d. STREET ADDRESS 1277 Walker Avenue - 21239	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 521-09-0176		17. INFORMANT ADDRESS Mrs. Mathilde J. Rhodus - 1277 Walker Ave. 21239	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST 4292 DUE TO, OR AS A CONSEQUENCE OF (b) CEREBROVASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (c) ASCND		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: CANCER OF TONGUE AND LARYNX					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 August 31 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from August 31 1982 to Sept. 2 1982 , that (I) (we) last saw the deceased alive on Sept 2 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ann D. Carter, MD		DEGREE MD		22c. DATE SIGNED 9-3-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANN D. CARTER		22e. ADDRESS J.L. Deaton Medical Center			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-4-82		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.		24. FUNERAL DIRECTOR NAME ADDRESS John C. Miller Inc-6415 Belair Rd.-21206		25a. DATE REC'D. BY REGISTRAR SEP 8 1982	
		25b. REGISTRAR'S SIGNATURE John J. Conish			

Items #10a-22a Film G572 10/26/82 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Jessie		LEE		Rice				X		9		25		1982		10:23	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
male	white	April 15, 1981		1 YRS.						9		25		1982		10:23	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Maryland		U.S.A.		WIDOWED		DIVORCED		Baltimore City		Baltimore		Johns Hopkins Hospital		NONE		NONE	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.	
Maryland		Harford Co.		Forest Hill		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2531 Sandy Hook Road		Michael Anthony Rice		Karen Lynn Corbin		No		NONE	
17. INFORMANT (Name)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		22a. I certify that I took charge of the remains described above, held on	
Mr. Michael A. Rice		PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Battered child syndrome</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: 9679 (b) _____ (c) _____						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR <u>?</u> MONTH <u>9</u> DAY <u>4</u> YEAR <u>1982</u>		child battered		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		22b. DATE		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION		22e. DATE REC'D. BY REGISTRAR		22f. REGISTRAR'S SIGNATURE	
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		home		2531 Sandy Hook Rd.		Sept. 28, 1982		Bel Air Memorial Gardens		Bel Air, Harford Co., Maryland		SEP 29 1982		John J. Gault	
22a. I certify that I took charge of the remains described above, held on		22b. DATE		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION		22e. DATE REC'D. BY REGISTRAR		22f. REGISTRAR'S SIGNATURE		22g. DATE REC'D. BY REGISTRAR		22h. REGISTRAR'S SIGNATURE		22i. DATE REC'D. BY REGISTRAR	
death resulted from: Natural cause <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		Sept. 28, 1982		Bel Air Memorial Gardens		Bel Air, Harford Co., Maryland		SEP 29 1982		John J. Gault		SEP 29 1982		John J. Gault		SEP 29 1982	
ACTUAL SIGNATURE		EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		DATE SIGNED		22g. DATE REC'D. BY REGISTRAR		22h. REGISTRAR'S SIGNATURE		22i. DATE REC'D. BY REGISTRAR		22j. REGISTRAR'S SIGNATURE		22k. DATE REC'D. BY REGISTRAR	
Hormez R. Guard, M.D.		111 Penn Street, Balto., MD 21201		111 Penn Street, Balto., MD 21201		9/26/82		SEP 29 1982		John J. Gault		SEP 29 1982		John J. Gault		SEP 29 1982	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE		23g. DATE REC'D. BY REGISTRAR		23h. REGISTRAR'S SIGNATURE		23i. DATE REC'D. BY REGISTRAR	
Burial		Sept. 28, 1982		Bel Air Memorial Gardens		Bel Air, Harford Co., Maryland		SEP 29 1982		John J. Gault		SEP 29 1982		John J. Gault		SEP 29 1982	
24. FUNERAL DIRECTOR		24a. NAME		24b. ADDRESS		24c. CITY OR TOWN		24d. STATE		24e. DATE REC'D. BY REGISTRAR		24f. REGISTRAR'S SIGNATURE		24g. DATE REC'D. BY REGISTRAR		24h. REGISTRAR'S SIGNATURE	
Joseph William Foster		W. Broadway & Williams St.		Baltimore, Maryland		Baltimore, Maryland		Baltimore, Maryland		SEP 29 1982		John J. Gault		SEP 29 1982		John J. Gault	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

2104

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 3 4 1 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Phillip		FIRST		MIDDLE		LAST Rice		2a. DATE OF DEATH MONTH DAY YEAR 9-20-82		2b. HOUR 3:10p M	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9/18/1926		6. AGE (IN YEARS LAST BIRTHDAY) 56		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY -0-	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 934 Brooks Lane			
14. FATHER'S NAME FIRST MIDDLE LAST Edward Rice						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizebeth Spencer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) -0-		16b. SOCIAL SECURITY NO. -0-		17. INFORMANT ADDRESS Wm. Rice 1511 N Fulton Ave. 21217							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4310 IMMEDIATE CAUSE (a) cerebral haemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Renal Failure											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 9-14 19 82 to 9-20 19 82 , that (I) (we) lost 9-20 19 82 above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Shay		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/20/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAVAD M SHAFI		22e. ADDRESS 2300 Garrison Bld									
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 9/25/82		23c. NAME OF CEMETERY OR CREMATORY Mt Calvary Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS Law Funeral Home 4611 Park Heights Ave.				25a. DATE REC'D. BY REGISTRAR SEP 24 1982		25b. REGISTRAR'S SIGNATURE John J. Lankish					



11-10-11
x

11-10-11

11-10-11 x

11-10-11

11-10-11

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11-10-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been issued by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial certificate. The funeral director should remove the certificate from the file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the funeral director must file a copy of this certificate with the State Dept. of Health and Mental Hygiene.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
FOR STATE REGISTRAR RICHARD J. BARTOS					8 2 2 3 4 1 5 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BARTOS RICHARD J.					2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 9, 1982			2b. HOUR 10:30 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 8-15-46		6. AGE (IN YEARS LAST BIRTHDAY) 36 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Phys. Education		12b. KIND OF BUSINESS OR INDUSTRY Towson St.	
13a. STATE MARYLAND		13b. COUNTY HARFORD		13c. CITY OR TOWN FALLSTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1704 BORDEAUX COURT 21047	
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD J. BARTOS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DOLORES KIESSLING					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216444619		17. INFORMANT ADDRESS CHARLOTTE D. BARTOS 1704 BORDEAUX CT.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) THROMBOCYTOPENIA 2051 DUE TO, OR AS A CONSEQUENCE OF (b) INFECTION DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE MYELOGENOUS LEUKEMIA								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 HOURS 1 WEEK TEN MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) UNDERLYING CHRONIC MYELOGENOUS LEUKEMIA									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from September 9, 1982 to September 9, 1982 , that (I) (we) last saw the deceased alive on September 9, 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE William R. Sigmund MD				DEGREE MD				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM R. SIGMUND				22e. ADDRESS JOHNS HOPKINS HOSPITAL					
23a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> OTHER <input type="checkbox"/>		23b. DATE 9-13-82		23c. NAME OF CEMETERY OR OTHER PLACE GARDENS OF RAITH		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR [Signature]				25a. DATE REC'D. BY REGISTRAR SEP 14 1982		25b. REGISTRAR'S SIGNATURE John J. Canine			

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1501 BOHEMIAN COURT

CHIEF IN CHARGE

2014 • J. Neurosci., July 23, 2014 • 34(30):9811–9821 • 9811

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CHRYSTIAN, REFORMER

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24-3-55

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[illegible]

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 4 1 6

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                           |                                                                                                                                     |                                                                                                                                                             |                                                                                                 |                                                                                          |                                       |
|-------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|---------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>EMILY GOULD RICHARDSON</b> |                                                                                                                                     |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>SEPTEMBER 24, 1982</b>                                |                                                                                          | 2b. HOUR<br><b>12:15<sub>M</sub>P</b> |
| 3. SEX<br><b>Female</b>                                                                   | 4. RACE<br><b>White</b>                                                                                                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 10, 1878</b>                                                                                                  |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>103</b><br>YRS. MONTHS DAYS HOURS MIN.             |                                       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                              | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                        |                                       |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3 Whitfield Rd.</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |                                                                                          | 12b. KIND OF BUSINESS OR INDUSTRY     |
| 13a. STATE<br><b>Maryland</b>                                                             | 13b. COUNTY                                                                                                                         | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>3 Whitfield Rd.</b>                                            |                                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Alexander Gould</b>                    |                                                                                                                                     |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Wilson</b>                             |                                                                                          |                                       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN)<br><b>No</b>          |                                                                                                                                     | 16b. SOCIAL SECURITY NO.<br><b>220-46-3439</b>                                                                                                              |                                                                                                 | 17. INFORMANT ADDRESS<br><b>304 North Wind Dr. Edward H. Richardson, Jr. Towson, Md.</b> |                                       |

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

4409

IMMEDIATE CAUSE (a) *Cardiac failure*

DUE TO, OR AS A CONSEQUENCE OF

(b) *Arteriosclerosis*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

## MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                      |  |                                                                                      |                                                                                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                     |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                               |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 24</u> , 19 <u>82</u> , to <u>Sept 24</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>Sept. 24</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                      |  |                                                                                      |                                                                                                                               |
| 22b. SIGNATURE<br><i>Edward H. Richardson, Jr. M.D.</i>                                                                                                                                                                                                                                                                                                                       |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>9/25/82</u>                                                   |                                                                                                                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Edward H. Richardson, Jr. M.D.</b>                                                                                                                                                                                                                                                                                                |  | 22e. ADDRESS<br><b>304 North Wind Rd. Towson, Md. 21204</b>                                                                                          |  |                                                                                      |                                                                                                                               |

|                                                                                        |                                    |                                                          |                                                                                |
|----------------------------------------------------------------------------------------|------------------------------------|----------------------------------------------------------|--------------------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                          | 23b. DATE<br><b>Sept. 29, 1982</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pikesville Balto. Co. Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212</b> |                                    | 25a. DATE REC'D BY REGISTRAR<br><b>OCT 1 1982</b>        |                                                                                |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                        |  |                                            |  |                                                                                                                                          |  |                                                                                                 |  |                                                                                                                                            |  | 8 2 2 3 4 1 7<br>REG. NO.                                                                                                     |  |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LUCRETIA RICHARDSON</b>                                                                                                                                                                                                                                                                                                              |  |                                            |  |                                                                                                                                          |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>9 28 82</b>                                              |  |                                                                                                                                            |  | 2b. HOUR<br><b>11<sup>10</sup> A M</b>                                                                                        |  |  |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><b>BLACK</b>                    |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>7 18 80</b>                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>2</b> YRS.                                                |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                          |  | 8. IF UNDER 24 HRS<br>HOURS MIN.                                                                                              |  |  |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                 |  | 10. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL BELLEVUE</b> |  | 12. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.                                        |  |                                                                                                                                            |  |                                                                                                                               |  |  |  |
| 13a. STATE<br><b>Ind</b>                                                                                                                                                                                                                                                                                                                                                    |  | 13b. COUNTY<br><b>BALTO.</b>               |  | 13c. CITY OR TOWN<br><b>BALTO.</b>                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>4319 REISTERSTOWN RD</b>                                                                                         |  | 21215                                                                                                                         |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Richardson</b>                                                                                                                                                                                                                                                                                                         |  |                                            |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Betty Moore</b>                                                                      |  |                                                                                                 |  |                                                                                                                                            |  |                                                                                                                               |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>                                                                                                                                                                                                                                                                                              |  |                                            |  | 16b. SOCIAL SECURITY NO.<br><b>NIA</b>                                                                                                   |  | 17. INFORMANT<br><b>Betty Richardson</b>                                                        |  |                                                                                                                                            |  | ADDRESS<br><b>3419 Reisterstown Rd</b> 21215                                                                                  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>3350 IMMEDIATE CAUSE (a) Cardiorespiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Wernicke-Hoffman Syndrome</b>                                                                   |  |                                            |  |                                                                                                                                          |  |                                                                                                 |  |                                                                                                                                            |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>31 hours</b><br><b>72 hours</b><br><b>Since birth</b>                   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>None</b>                                                                                                                                                                                                                           |  |                                            |  |                                                                                                                                          |  |                                                                                                 |  |                                                                                                                                            |  |                                                                                                                               |  |  |  |
| 19a. DATE OF OPERATION<br><b>None</b>                                                                                                                                                                                                                                                                                                                                       |  |                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>None</b>                                                                          |  |                                                                                                 |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                     |  |                                            |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |                                                                                                                                            |  |                                                                                                                               |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                   |  |                                            |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |  |                                                                                                                                            |  |                                                                                                                               |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 26</b> , 19 <b>82</b> , to <b>Sept 28</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>Sept 28</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                            |  |                                                                                                                                          |  |                                                                                                 |  |                                                                                                                                            |  |                                                                                                                               |  |  |  |
| 22b. SIGNATURE<br><b>Robert A Wood</b>                                                                                                                                                                                                                                                                                                                                      |  |                                            |  | DEGREE<br><b>MD</b>                                                                                                                      |  |                                                                                                 |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>9/28/82</b>                                                                                            |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert A Wood MD</b>                                                                                                                                                                                                                                                                                                            |  |                                            |  | 22e. ADDRESS<br><b>Sinai Hospital, Dept of Pediatrics</b>                                                                                |  |                                                                                                 |  |                                                                                                                                            |  |                                                                                                                               |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>                                                                                                                                                                                                                                                                                                                  |  |                                            |  | 23b. DATE<br><b>10/2/82</b>                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cem.</b>                                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                                                                         |  |                                                                                                                               |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Avenue</b>                                                                                                                                                                                                                                                                                        |  |                                            |  |                                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 29 1982</b>                                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canfield</b>                                                                                      |  |                                                                                                                               |  |  |  |

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Handwritten notes on lined paper, including a large 'X' mark and various illegible text.



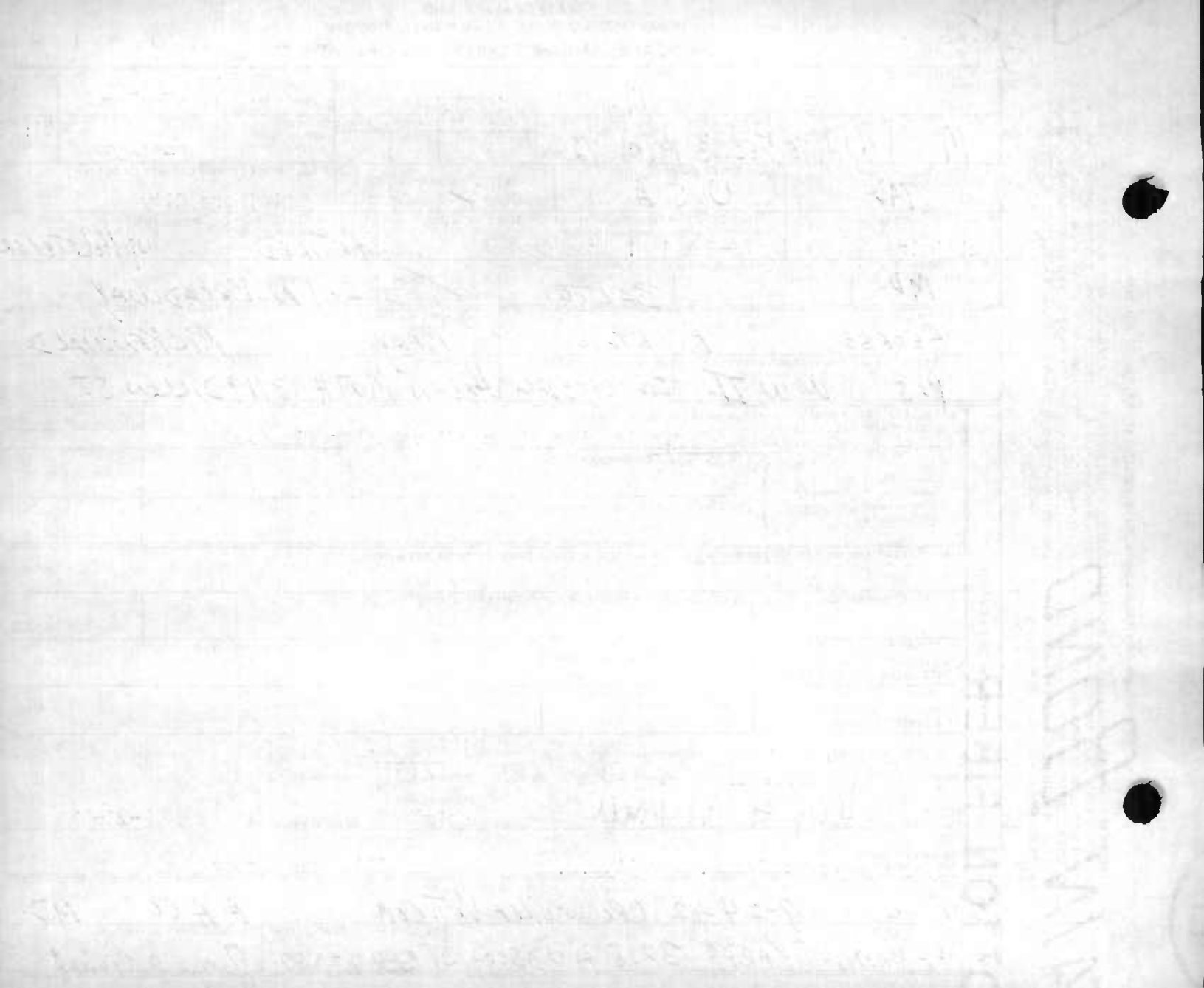
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                        |         |                                                                                                            |  |                                                                 |  |                                                                     |  |                                                                               |  |                                |  |                                                                     |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|--|---------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|--------------------------------|--|---------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                    |         | FIRST                                                                                                      |  | MIDDLE                                                          |  | LAST                                                                |  | 2a. DATE KNOWN<br>OF DEATH                                                    |  | XX MONTH DAY YEAR              |  | 2b. HOUR                                                            |  |
| GEORGE                                                                                                                                                                                                                                                                                                                                                                                                                                                 |         | M.                                                                                                         |  | RICHTER                                                         |  |                                                                     |  | 9-21-82                                                                       |  | 19                             |  | M                                                                   |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE | 5. DATE OF BIRTH                                                                                           |  | 6. AGE (IN YEARS)                                               |  | IF UNDER 1 YR.                                                      |  | IF UNDER 24 HRS.                                                              |  | 7c. DATE<br>PRONOUNCED<br>DEAD |  | 7d. HOUR                                                            |  |
| M                                                                                                                                                                                                                                                                                                                                                                                                                                                      | WHITE   | FEB. 3, 1910                                                                                               |  | 72 YRS.                                                         |  |                                                                     |  |                                                                               |  | 9-21-82                        |  | 11:14 am                                                            |  |
| 8. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                            |         | 7b. CITIZEN OF WHAT COUNTRY?                                                                               |  | 8. MARRIED                                                      |  | NEVER MARRIED                                                       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                          |  |                                |  |                                                                     |  |
| MD.                                                                                                                                                                                                                                                                                                                                                                                                                                                    |         | U.S.A.                                                                                                     |  | WIDOWED                                                         |  | DIVORCED                                                            |  | Baltimore City                                                                |  |                                |  |                                                                     |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                              |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>OR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                |  |                                                                               |  |                                |  |                                                                     |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                              |         | Apt 8-G 201 N. Broadway                                                                                    |  | RETIRED                                                         |  | UPHOLSTERER                                                         |  |                                                                               |  |                                |  |                                                                     |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                             |         | 13b. COUNTY                                                                                                |  | 13c. CITY OR TOWN                                               |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS                                                           |  |                                |  |                                                                     |  |
| MD.                                                                                                                                                                                                                                                                                                                                                                                                                                                    |         |                                                                                                            |  | BALTO.                                                          |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 201 N. BROADWAY                                                               |  |                                |  |                                                                     |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                      |         | 15. MOTHER'S MAIDEN NAME                                                                                   |  |                                                                 |  |                                                                     |  |                                                                               |  |                                |  |                                                                     |  |
| GEORGE                                                                                                                                                                                                                                                                                                                                                                                                                                                 |         | MARY                                                                                                       |  | RICKENWALD                                                      |  |                                                                     |  |                                                                               |  |                                |  |                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                  |         | 16b. SOCIAL SECURITY NO.                                                                                   |  | 17. INFORMANT                                                   |  | ADDRESS                                                             |  |                                                                               |  |                                |  |                                                                     |  |
| YES                                                                                                                                                                                                                                                                                                                                                                                                                                                    |         | 216-01-5126                                                                                                |  | HELEN MUTH                                                      |  | 3119 DILLON ST.                                                     |  |                                                                               |  |                                |  |                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>4292<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                                                                           |         |                                                                                                            |  |                                                                 |  |                                                                     |  |                                                                               |  |                                |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).                                                                                                                                                                                                                                                                                                                    |         |                                                                                                            |  |                                                                 |  |                                                                     |  |                                                                               |  |                                |  |                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                 |         |                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?               |  |                                                                     |  |                                                                               |  |                                |  | 20. AUTOPSY?                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                        |         |                                                                                                            |  |                                                                 |  |                                                                     |  |                                                                               |  |                                |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                              |         |                                                                                                            |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19      |  |                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                |  |                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                        |         |                                                                                                            |  |                                                                 |  |                                                                     |  |                                                                               |  |                                |  |                                                                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                  |         |                                                                                                            |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)  |  |                                                                     |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |                                |  |                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                        |         |                                                                                                            |  |                                                                 |  |                                                                     |  |                                                                               |  |                                |  |                                                                     |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |         |                                                                                                            |  |                                                                 |  |                                                                     |  |                                                                               |  |                                |  |                                                                     |  |
| ACTUAL<br>SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                    |         |                                                                                                            |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER              |  |                                                                     |  | DATE 9-21-82<br>SIGNED                                                        |  |                                |  |                                                                     |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                     |         |                                                                                                            |  | ADDRESS                                                         |  |                                                                     |  |                                                                               |  |                                |  |                                                                     |  |
| Margarita A. Korell, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                              |         |                                                                                                            |  | 111 Penn Street                                                 |  |                                                                     |  |                                                                               |  |                                |  |                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                           |         |                                                                                                            |  | 23b. DATE                                                       |  |                                                                     |  | 23c. NAME OF CEMETERY OR CREMATORY                                            |  |                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |
| BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                 |         |                                                                                                            |  | 9-24-82                                                         |  |                                                                     |  | CROWNSVILLE VET. CEM.                                                         |  |                                |  | A-A-CO. MD.                                                         |  |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                                                                                                           |         |                                                                                                            |  | ADDRESS                                                         |  |                                                                     |  | 25a. DATE REC'D. BY REGISTRAR                                                 |  |                                |  | 25b. REGISTRAR'S SIGNATURE                                          |  |
| HOFFMANN-SKARDA                                                                                                                                                                                                                                                                                                                                                                                                                                        |         |                                                                                                            |  | 3218 HUDSON ST                                                  |  |                                                                     |  | SEP 23 1982                                                                   |  |                                |  | John J. Carver                                                      |  |

0604 BP





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

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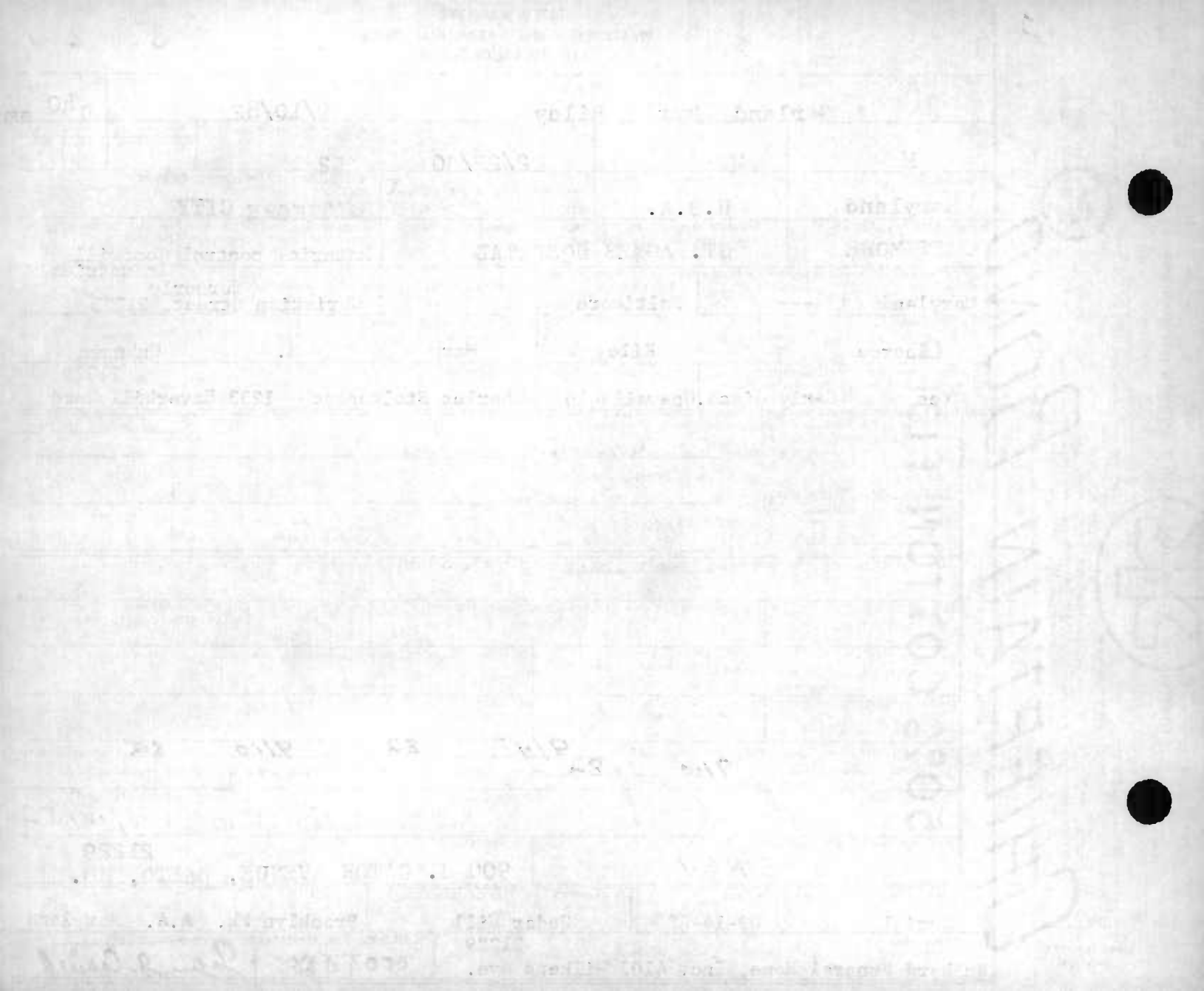


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                    |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                               |                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                            |  | REG. NO. 8 2 2 3 4 2 0                                                                                                          |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                               |                                                 |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Garland Edward Riley                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                 |  |                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9/10/82                                       |  | 2b. HOUR<br>140 am                                                                                                            |                                                 |
| 3. SEX<br>M                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br>W                                                                                                                    |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2/22/30                                                                                                               |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>52 YRS.                                           |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |                                                 |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                          |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |                                                                                                                               |                                                 |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Material control |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Goodwill Industries                                                                      |                                                 |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                                                                                                  |  |                                                                                                                                 |  |                                                                                                                                                             |  | 13b. COUNTY<br>---                                                                   |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                |                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Riley                                                                                                                                                                                                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary E. Unknown                                                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                        |  |                                                                                      |  |                                                                                                                               |                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                             |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>Early disch. Unavailable                                             |  | 17. INFORMANT<br>ADDRESS<br>Charles Stolzenbach 1233 Haverhill Road 21229                                                                                   |  |                                                                                      |  |                                                                                                                               |                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory failure</u><br>4920<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Emphysema massive</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Chronic COPD and infection</u>                                                         |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                                                                    |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                               |                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br>P.M. 19                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR                                                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                      |  |                                                                                                                               |                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                          |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                      |  |                                                                                                                               |                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/4</u> , 19 <u>82</u> , to <u>9/10</u> , 19 <u>82</u> , that (I) (we) lost<br>saw the deceased alive on <u>9/10</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                               |                                                 |
| 22b. SIGNATURE<br><u>M. Singh</u>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                 |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |                                                                                      |  | 22c. DATE SIGNED<br>9/10/82                                                                                                   |                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>M. SINGH                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                 |  | 22e. ADDRESS<br>21229<br>900 S. CATON AVENUE, BALTO, MD.                                                                                                    |  |                                                                                      |  |                                                                                                                               |                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br>09-14-82                                                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill                                                                                                            |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brooklyn Pk. A.A. Maryland             |  |                                                                                                                               |                                                 |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.                                                                                                                                                                                                                                                                                            |  |                                                                                                                                 |  | 25a. DATE RECEIVED BY REGISTRAR<br>21229<br>SEP 14 1982                                                                                                     |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Connel</u>                                  |  |                                                                                                                               |                                                 |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8 2 2 3 4 2 1

|                                                                                                                                                                                                                                                                                                                                   |                                                                                                           |                                                                                                                                                             |                                      |                                                                                      |                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                      |                                                                                                           | 2a. DATE OF DEATH                                                                                                                                           |                                      | 2b. HOUR                                                                             |                                                 |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                               |                                                                                                           | 2a. DATE OF DEATH                                                                                                                                           |                                      | 2b. HOUR                                                                             |                                                 |
| FIRST MIDDLE LAST<br>A IL DA ROBB                                                                                                                                                                                                                                                                                                 |                                                                                                           | 9/9/82                                                                                                                                                      |                                      | M                                                                                    |                                                 |
| 3. SEX                                                                                                                                                                                                                                                                                                                            | 4. RACE                                                                                                   | 5. DATE OF BIRTH                                                                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)      | 8. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                         |                                                 |
| F                                                                                                                                                                                                                                                                                                                                 | B                                                                                                         | 1/31/10                                                                                                                                                     | 72                                   | YRS.                                                                                 |                                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                         | 7b. CITIZEN OF WHAT COUNTRY?                                                                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH |                                                                                      |                                                 |
| Md.                                                                                                                                                                                                                                                                                                                               | USA                                                                                                       |                                                                                                                                                             | Baltimore City MD.                   |                                                                                      |                                                 |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |                                      | 12b. KIND OF BUSINESS OR INDUSTRY                                                    |                                                 |
| Baltimore                                                                                                                                                                                                                                                                                                                         | Bon Secours Hospital                                                                                      | Retired                                                                                                                                                     |                                      |                                                                                      |                                                 |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                      |                                                                                                           | 13b. INSIDE CITY LIMITS?                                                                                                                                    | 13c. STREET ADDRESS                  |                                                                                      |                                                 |
| 13a. STATE                                                                                                                                                                                                                                                                                                                        |                                                                                                           | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                         | 835 Woodward St.                     |                                                                                      |                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                            |                                                                                                           | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                                                                               |                                      |                                                                                      |                                                 |
| Charles Wheatley                                                                                                                                                                                                                                                                                                                  |                                                                                                           | Mary Wheatley                                                                                                                                               |                                      |                                                                                      |                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                              |                                                                                                           | 16b. SOCIAL SECURITY NO.                                                                                                                                    |                                      | 17. INFORMANT ADDRESS                                                                |                                                 |
| NO                                                                                                                                                                                                                                                                                                                                |                                                                                                           | 214-18-0477                                                                                                                                                 |                                      | Louise Jackson 1018 N Calhoun St.                                                    |                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4100                                                                                                                                                                                              |                                                                                                           |                                                                                                                                                             |                                      |                                                                                      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial Infarction</i>                                                                                                                                                                                                                                                                   |                                                                                                           |                                                                                                                                                             |                                      |                                                                                      |                                                 |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                                                                |                                                                                                           |                                                                                                                                                             |                                      |                                                                                      |                                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                               |                                                                                                           |                                                                                                                                                             |                                      |                                                                                      |                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                            |                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                          |                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                      |                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |                                                                                                           |                                                                                                                                                             |                                      |                                                                                      |                                                 |
| 22b. SIGNATURE<br>DEGREE<br>Attending Physician                                                                                                                                                                                                                                                                                   |                                                                                                           |                                                                                                                                                             |                                      | 22c. DATE SIGNED<br>9/14/82                                                          |                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Patricia A. Sabunsky                                                                                                                                                                                                                                                                     |                                                                                                           |                                                                                                                                                             |                                      | 22e. ADDRESS                                                                         |                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                      |                                                                                                           | 23b. DATE                                                                                                                                                   |                                      | 23c. NAME OF CEMETERY OR CREMATORY                                                   |                                                 |
| Burial                                                                                                                                                                                                                                                                                                                            |                                                                                                           | 9/14/82                                                                                                                                                     |                                      | Mt. Auburn                                                                           |                                                 |
| 23d. LOCATION<br>CITY OR TOWN                                                                                                                                                                                                                                                                                                     |                                                                                                           | 23e. COUNTY                                                                                                                                                 |                                      | 23f. STATE                                                                           |                                                 |
| Balto.                                                                                                                                                                                                                                                                                                                            |                                                                                                           | Md.                                                                                                                                                         |                                      | Md.                                                                                  |                                                 |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                      |                                                                                                           |                                                                                                                                                             |                                      | 25a. DATE REC'D. BY REGISTRAR                                                        |                                                 |
| Chas. A. Rice FSPA 1300 Eutaw Pl.                                                                                                                                                                                                                                                                                                 |                                                                                                           |                                                                                                                                                             |                                      | SEP 16 1982                                                                          |                                                 |
| 25b. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                        |                                                                                                           |                                                                                                                                                             |                                      | 25c. REGISTRAR'S SIGNATURE                                                           |                                                 |
|                                                                                                                                                                                                                                                                                                                                   |                                                                                                           |                                                                                                                                                             |                                      | John J. Conner                                                                       |                                                 |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as required by law.

item 8 #G572 10/26/82 ph

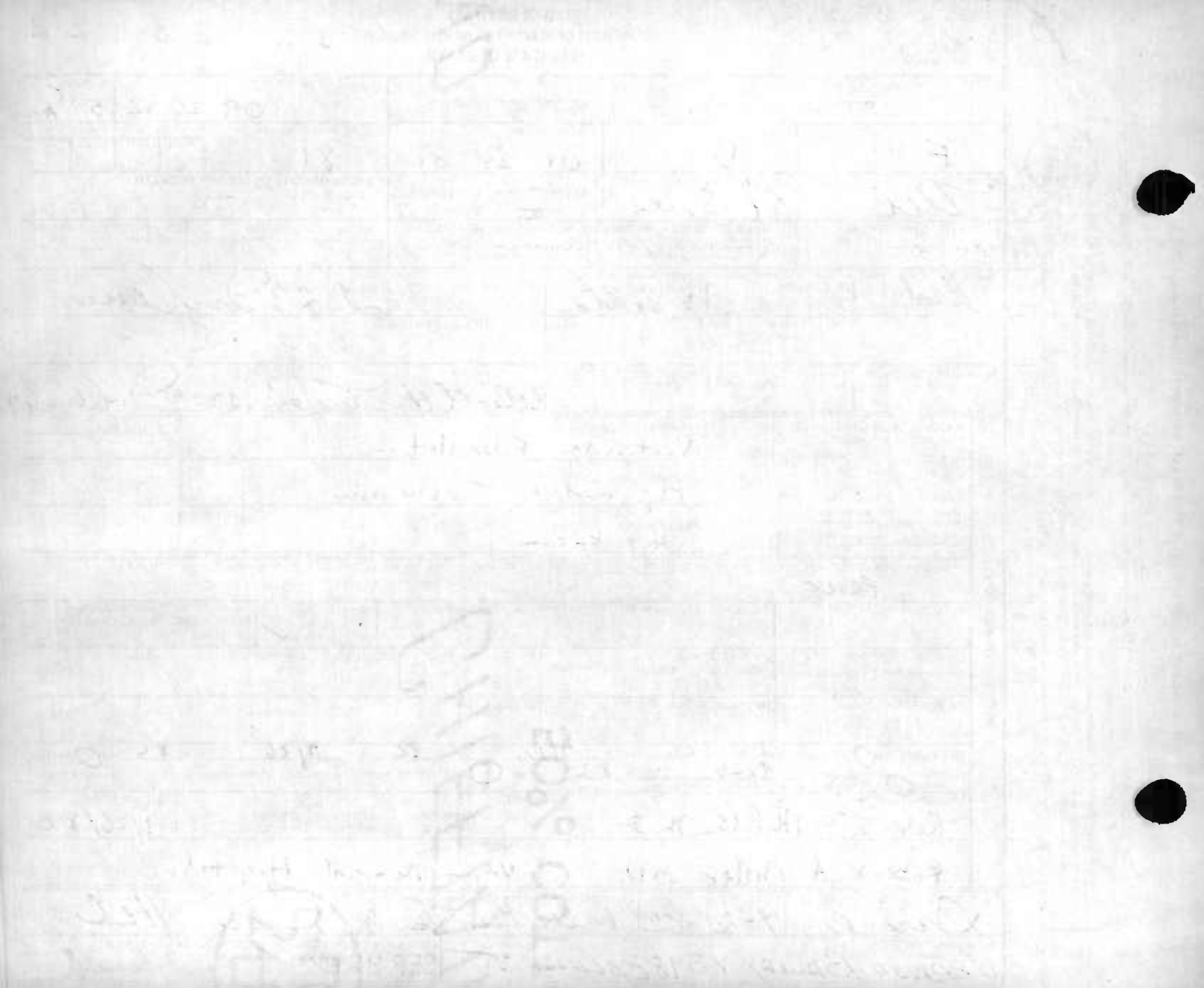
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 4 2 2

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                      |                                                                                                                                                             |                                                                                      |                                                                                                                            |                                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>RACHEL C. ROBERTS                                                                                                                                                                                                                                                                                   |                                                                                                                                      |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br>09 26 82                                         |                                                                                                                            | 2b. HOUR<br>5:45 AM                                             |
| 3. SEX<br>F                                                                                                                                                                                                                                                                                                                                                  | 4. RACE<br>B                                                                                                                         | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>05 28 01                                                                                                              |                                                                                      | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>81 YRS                                                                                | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.                                                                                                                                                                                                                                                                                                             | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                                                 |                                                                 |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |                                                                                                                                                             |                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                           |                                                                 |
| 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                            |                                                                                                                                      |                                                                                                                                                             |                                                                                      |                                                                                                                            |                                                                 |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.                                                                                                                                                                                                                                            | 13b. COUNTY<br>Baltimore                                                                                                             | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>2323 Dryden Ave                                                                                     |                                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                                                        |                                                                                                                                                             |                                                                                      |                                                                                                                            |                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)                                                                              | 17. INFORMANT<br>ADDRESS<br>Elliott Harrington 2323 Dryden Ave                                                                                              |                                                                                      |                                                                                                                            |                                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ventricular F. brillation</u><br>4148<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Myocardial Ischemia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Hypertension</u>                                                   |                                                                                                                                      |                                                                                                                                                             |                                                                                      |                                                                                                                            |                                                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Fever</u>                                                                                                                                                                                                         |                                                                                                                                      |                                                                                                                                                             |                                                                                      |                                                                                                                            |                                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                     |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)                                                                              |                                                                                      |                                                                                                                            |                                                                 |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                    | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                      |                                                                                                                            |                                                                 |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>7/16</u> , 19 <u>82</u> , to <u>7/26</u> , 19 <u>82</u> , that (1) (we) last saw the deceased alive on <u>7/26</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) not view the body after death. |                                                                                                                                      |                                                                                                                                                             |                                                                                      |                                                                                                                            |                                                                 |
| 22b. SIGNATURE<br><u>Robert A Miller MD</u>                                                                                                                                                                                                                                                                                                                  |                                                                                                                                      | DEGREE                                                                                                                                                      |                                                                                      | 22c. DATE SIGNED<br>9/26/82                                                                                                |                                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert A Miller MD                                                                                                                                                                                                                                                                                                  |                                                                                                                                      | 22e. ADDRESS<br>Union Memorial Hospital                                                                                                                     |                                                                                      |                                                                                                                            |                                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                 | 23b. DATE<br>9-30-82                                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br>Crestwood View AK                                                                                                     |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md                                                                 |                                                                 |
| 24. FUNERAL DIRECTOR<br>NAME<br>VERNON BALIKX 1348 CALHOUN ST                                                                                                                                                                                                                                                                                                |                                                                                                                                      | 25a. DATE REC'D. BY REGISTRAR<br>SEP 29 1982                                                                                                                |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br>John J. Ganiel                                                                               |                                                                 |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

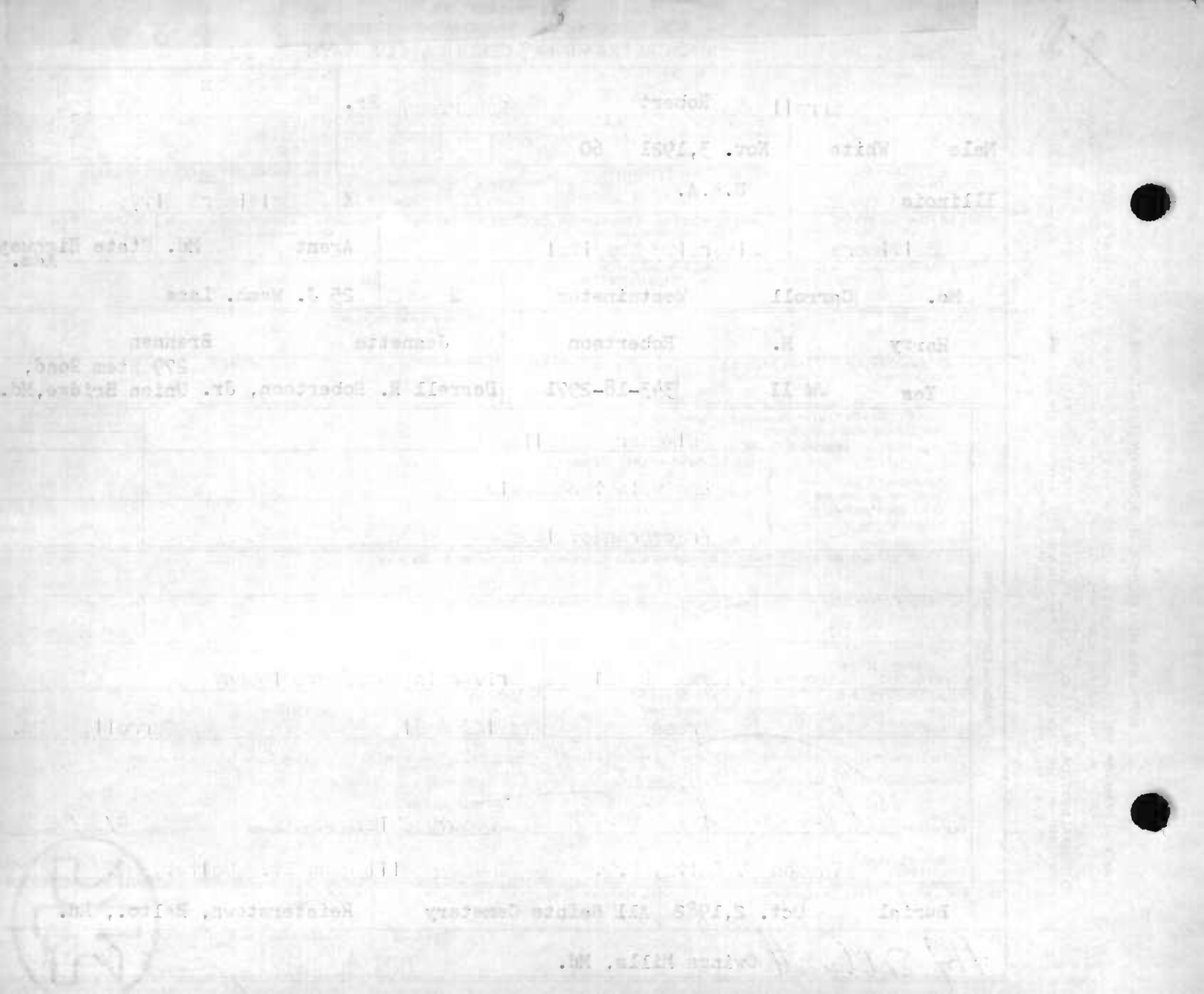
BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                         |  |                                                                                                                                          |  |                                                                                            |  |                                                                                                                                                             |  |                                                                                                           |  |                                                                                     |  |                      |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|----------------------|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 2                       |  | 2                                                                                                                                        |  | 3                                                                                          |  | 4                                                                                                                                                           |  | 2                                                                                                         |  | 3                                                                                   |  |                      |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Darrell Robert Robertson Sr.</b>                                                                                                                                                                                                                                                                                                                                                                    |  |                         |  |                                                                                                                                          |  |                                                                                            |  |                                                                                                                                                             |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>9 30 19 82</b> |  |                                                                                     |  | 2b. HOUR<br><b>M</b> |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE<br><b>White</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Nov. 3, 1921</b>                                                                                   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>60</b> YRS.                                        |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.                                                                                                                       |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>9 30 19 82</b>                                              |  | 2d. HOUR<br><b>9 A</b>                                                              |  |                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Illinois</b>                                                                                                                                                                                                                                                                                                                                                                               |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                            |  |                                                                                            |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |                                                                                                           |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.                  |  |                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                              |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |  |                                                                                            |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Agent</b>                                                                               |  |                                                                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Md. State Highway Adm.</b>                  |  |                      |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                         |  | 13b. COUNTY<br><b>Carroll</b>                                                                                                            |  | 13c. CITY OR TOWN<br><b>Westminster</b>                                                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  | 13e. STREET ADDRESS<br><b>25 J. Wash. Lane</b>                                                            |  |                                                                                     |  |                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry M. Robertson</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                         |  |                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Jeanette Brennan</b>                   |  |                                                                                                                                                             |  |                                                                                                           |  |                                                                                     |  |                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>Yes</b><br>(IF YES, GIVE WAR OR DATES) <b>WW II</b>                                                                                                                                                                                                                                                                                                               |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>343-18-2971</b>                                                                                           |  | 17. INFORMANT ADDRESS<br><b>279 Stem Road, Darrell R. Robertson, Jr. Union Bridge, Md.</b> |  |                                                                                                                                                             |  |                                                                                                           |  |                                                                                     |  |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary embolism</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b>Leg vein thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Fractures of legs</b>                                           |  |                         |  |                                                                                                                                          |  |                                                                                            |  |                                                                                                                                                             |  |                                                                                                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                        |  |                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).                                                                                                                                                                                                                                                                                                        |  |                         |  |                                                                                                                                          |  |                                                                                            |  |                                                                                                                                                             |  |                                                                                                           |  |                                                                                     |  |                      |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                        |  |                                                                                            |  |                                                                                                                                                             |  |                                                                                                           |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                      |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                          |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>7:25xx 9 21 19 82</b>                                                              |  |                                                                                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>Driver in auto/auto impact</b>                                          |  |                                                                                                           |  |                                                                                     |  |                      |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                       |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>road</b>                                                               |  |                                                                                            |  | 21i. LOCATION<br>STREET<br><b>Rts 140 &amp; 91</b>                                                                                                          |  | CITY OR TOWN<br><b>Carroll,</b>                                                                           |  | STATE<br><b>Md.</b>                                                                 |  |                      |  |
| 22. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .<br>Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                         |  |                                                                                                                                          |  |                                                                                            |  |                                                                                                                                                             |  |                                                                                                           |  |                                                                                     |  |                      |  |
| ACTUAL SIGNATURE<br><i>Thomas D. Smith</i>                                                                                                                                                                                                                                                                                                                                                                                                 |  |                         |  | TITLE (SPECIFY)<br><b>Deputy Chief</b>                                                                                                   |  |                                                                                            |  | MEDICAL EXAMINER                                                                                                                                            |  |                                                                                                           |  | DATE SIGNED<br><b>9/30/82</b>                                                       |  |                      |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Thomas D. Smith, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                            |  |                         |  | ADDRESS<br><b>111 Penn St. Balto., MD.</b>                                                                                               |  |                                                                                            |  |                                                                                                                                                             |  |                                                                                                           |  |                                                                                     |  |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |                         |  | 23b. DATE<br><b>Oct. 2, 1982</b>                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>All Saints Cemetery</b>                           |  |                                                                                                                                                             |  | 23d. LOCATION<br>(CITY OR TOWN) COUNTY STATE<br><b>Reisterstown, Balto., Md.</b>                          |  |                                                                                     |  |                      |  |
| 24. FUNERAL DIRECTOR<br><i>H. H. Eckhardt</i>                                                                                                                                                                                                                                                                                                                                                                                              |  |                         |  |                                                                                                                                          |  | ADDRESS<br><b>Owings Mills, Md.</b>                                                        |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 4 1982</b>                                                                                                          |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Conner</i>                                                       |  |                                                                                     |  |                      |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  |                                                                                                                                   |                                                                         |                                                                                                                                                             |                                                                                                          |                                                                            |                                                                                     |                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Patricia Louise Robertson                                                                                                                                                                                                                                                                                                                                                 |                  |                                                                                                                                   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>9 29 1982     |                                                                                                                                                             |                                                                                                          | 2b. HOUR<br>M<br>5:45P                                                     |                                                                                     |                                              |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                      | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 12 46                                                                                     | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>36 YRS.                           | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                                                                                                    | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>9 29 1982                                                  | 2d. HOUR<br>M                                                              |                                                                                     |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                 |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                            |                                                                         | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                |                                                                                     |                                              |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |                                                                         |                                                                                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>housewife                               |                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br>own home                                       |                                              |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                   | 13b. CITY OR TOWN<br>Carroll                                            |                                                                                                                                                             | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |                                                                            | 13e. STREET ADDRESS<br>316 Main St.                                                 |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Fulton Green Woldrop                                                                                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Catherine Whitfield    |                                                                                                                                                             |                                                                                                          | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No |                                                                                     |                                              |
| 16b. SOCIAL SECURITY NO.<br>none                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                   | 17. INFORMANT<br>316 Main St. New Windsor, Md.<br>Robert Robertson, Sr. |                                                                                                                                                             |                                                                                                          | 17. INFORMANT                                                              |                                                                                     |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>8809 IMMEDIATE CAUSE (a) Cranio cerebral trauma<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                            |                  |                                                                                                                                   |                                                                         |                                                                                                                                                             |                                                                                                          |                                                                            |                                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                   |                                                                         |                                                                                                                                                             |                                                                                                          |                                                                            |                                                                                     |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                       |                                                                                                                                                             |                                                                                                          |                                                                            | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                              |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                   | 21b. TIME OF INJURY<br>HOUR, MONTH DAY YEAR<br>3:49 M. 9 27 1982        |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject fell down steps |                                                                            |                                                                                     |                                              |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                  |                  |                                                                                                                                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>home     |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>316 Main St. New Windsor Carroll Md.                |                                                                            |                                                                                     |                                              |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                  |                                                                                                                                   |                                                                         |                                                                                                                                                             |                                                                                                          |                                                                            |                                                                                     |                                              |
| ACTUAL SIGNATURE<br>Thomas D. Smith                                                                                                                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                   | TITLE (SPECIFY)<br>Deputy Chief                                         |                                                                                                                                                             |                                                                                                          | DATE SIGNED<br>9/30/82                                                     |                                                                                     |                                              |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Thomas D. Smith, M.D.                                                                                                                                                                                                                                                                                                                                                                           |                  |                                                                                                                                   | ADDRESS<br>111 Penn St. Balto., Md.                                     |                                                                                                                                                             |                                                                                                          |                                                                            |                                                                                     |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                   | 23b. DATE<br>10/2/82                                                    |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Pipe Creek Cemetery                                                |                                                                            | 23d. LOCATION<br>TOWN COUNTY STATE<br>New Windsor Carroll Md.                       |                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br>D. D. Hartzler                                                                                                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                   | ADDRESS<br>New Windsor, Md.                                             |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>OCT 1 - 1982                                                            |                                                                            | 25b. REGISTRAR'S SIGNATURE<br>John J. Carver                                        |                                              |

1. Name: *James White*  
 2. Age: *32*  
 3. Sex: *M*  
 4. Height: *5' 10"*  
 5. Weight: *175*  
 6. Eyes: *Blue*  
 7. Hair: *Brown*  
 8. Occupation: *Farmer*  
 9. Address: *123 Main St.,  
 Springfield, Mass.*  
 10. Date: *Jan 15, 1900*  
 11. Signature: *[Signature]*  
 12. Initials: *JW*

13. Remarks: *Good character, no record.*  
 14. Date: *Jan 15, 1900*  
 15. Signature: *[Signature]*  
 16. Initials: *[Initials]*  
 17. Name: *John Green*  
 18. Age: *25*  
 19. Sex: *M*  
 20. Height: *5' 8"*  
 21. Weight: *160*  
 22. Eyes: *Green*  
 23. Hair: *Black*  
 24. Occupation: *Teacher*  
 25. Address: *456 Oak St.,  
 Boston, Mass.*  
 26. Date: *Jan 15, 1900*  
 27. Signature: *[Signature]*  
 28. Initials: *JG*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 4 2 5

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                              |                                                                                                                                                             |                                                                                          |                                                                                                 |                                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ARTHUR W. ROBINSON</b>                                                                                                                                                                                                                                                                                                                           |                                                                                                                                              |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>SEPT. 10, 1982</b>                             |                                                                                                 | 2b. HOUR<br><b>4:06AM</b>                                        |
| 3. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                      | 4. RACE<br><b>white</b>                                                                                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 18 1921</b>                                                                                                      |                                                                                          | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.                                               | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                               | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |                                                                  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>North Charles Gen. Hosp.</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Tool Designer</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Martin</b>                                              |                                                                  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                              | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                             | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                    | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James F. Robinson</b>                                                                                                                                                                                                                                                                                                                         |                                                                                                                                              | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bessie Mach</b>                                                                                         |                                                                                          |                                                                                                 |                                                                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>                                                                                                                                                                                                                                                                                                          |                                                                                                                                              | 16b. SOCIAL SECURITY NO.<br><b>217-16-0770</b>                                                                                                              |                                                                                          | 17. INFORMANT<br>ADDRESS<br><b>Frances Robinson, 1523 Argonne Dr.</b>                           |                                                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4280</b> IMMEDIATE CAUSE (a) <b>Severe Chronic Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                                                                                                                                              |                                                                                                                                                             |                                                                                          |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Cellulitis of legs, Renal failure, Diabetes Mellitus</b>                                                                                                                                                                                        |                                                                                                                                              |                                                                                                                                                             |                                                                                          |                                                                                                 |                                                                  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                          | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                                                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                   |                                                                                                                                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                               |                                                                                                                                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>AUG. 23, 1982</b> , to <b>SEPT. 10, 1982</b> , that (I) (we) lost<br>saw the deceased alive on <b>Sept. 10, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                   |                                                                                                                                              |                                                                                                                                                             |                                                                                          |                                                                                                 |                                                                  |
| 22b. SIGNATURE<br><b>C. VERGARA SOARES</b>                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                              | DEGREE<br><b>M.D.</b>                                                                                                                                       |                                                                                          | 22c. DATE SIGNED<br><b>9-10-82</b>                                                              |                                                                  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. VERGARA SOARES</b>                                                                                                                                                                                                                                                                                                                          |                                                                                                                                              | 22e. ADDRESS<br><b>N. CHARLES GEN. HOSP. BALT. MD. 21218</b>                                                                                                |                                                                                          |                                                                                                 |                                                                  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                              | 23b. DATE<br><b>9-13-82</b>                                                                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>                                                                                               |                                                                                          | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Overlea Balto., Md.</b>                        |                                                                  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Larsen Funeral Home</b>                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                              | ADDRESS<br><b>7901 Belair Rd</b>                                                                                                                            |                                                                                          | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 15 1982</b>                                             | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>              |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DATA IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                             |                                                             |                                                                                                                                                             |                                                                               |                                                                                                 |                                                                                     |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Kimberly Robinson</b>                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                             | 2a. DATE KNOWN OF DEATH<br>XX MONTH DAY YEAR<br>9 16 19 82  |                                                                                                                                                             |                                                                               | 2b. HOUR<br>8:20 a. m.                                                                          |                                                                                     |                                              |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                  | 4. RACE<br><b>Negro</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 18 82                                                                                               | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br>1                | IF UNDER 1 YR.<br>MONTHS DAYS<br>2                                                                                                                          | IF UNDER 24 HRS.<br>HOURS MIN.<br>00                                          | 2c. DATE PRONOUNCED DEAD<br>9 16 19 82                                                          |                                                                                     |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                             |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                  |                                                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.                              |                                                                                     |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                            |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Johns Hopkins Hospital</b> |                                                             |                                                                                                                                                             |                                                                               | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |                                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                            |                         | 13b. COUNTY<br><b>Baltimore</b>                                                                                                             |                                                             | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                                                                               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                     |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>David Ray</b>                                                                                                                                                                                                                                                                                                                                                                               |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Carrie Robinson</b>                                                                     |                                                             | 13e. STREET ADDRESS<br><b>5017 Goodnow Road</b>                                                                                                             |                                                                               |                                                                                                 |                                                                                     |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                       |                         | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>                                                                                                      |                                                             | 17. INFORMANT ADDRESS<br><b>Carrie Robinson 5017 Goodnow Road</b>                                                                                           |                                                                               |                                                                                                 |                                                                                     |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sudden Infant Death Syndrome</b><br>7980<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF                                                               |                         |                                                                                                                                             |                                                             |                                                                                                                                                             |                                                                               |                                                                                                 |                                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                             |                                                             |                                                                                                                                                             |                                                                               |                                                                                                 |                                                                                     |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                                                                                                                                                             |                                                                               |                                                                                                 | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                                                                                 |                                                                                     |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                             | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |                                                                                                 |                                                                                     |                                              |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |                                                                                                                                             |                                                             |                                                                                                                                                             |                                                                               |                                                                                                 |                                                                                     |                                              |
| ACTUAL SIGNATURE<br><b>Margie A. Korell</b>                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                             | TITLE (SPECIFY)<br><b>Assistant</b>                         |                                                                                                                                                             |                                                                               | DATE SIGNED<br><b>9-16-82</b>                                                                   |                                                                                     |                                              |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                             | ADDRESS<br><b>111 Penn Street</b>                           |                                                                                                                                                             |                                                                               |                                                                                                 |                                                                                     |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                             | 23b. DATE<br><b>9/20/82</b>                                 |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Eastview Memorial Park</b>           |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>            |                                              |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. MARCH F/H INC. 1101 E. NORTH AVENUE</b>                                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                             |                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 21 1982</b>                                                                                                         |                                                                               | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                             |                                                                                     |                                              |

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 08-17-2010 BY 60322 UCBAW

10/1/81

11/1/81

12/1/81

RECEIVED  
FBI  
OCT 1 1981

RECEIVED  
FBI  
OCT 1 1981



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 4 2 7  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                               |                                                                                                 |                                                                 |                                                                                                                               |                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Leo Robinson</b>                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 29 82</b>                  |                                                                                                                                                             |                                                               | 2b. HOUR<br>M<br><b>AM</b>                                                                      |                                                                 |                                                                                                                               |                                                 |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><b>BLACK</b>                                                                                                                 |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 11 95</b>                                                                                                        |                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.                                               |                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                              |                                                 |
| 7a. BIRTHPLACE<br>(COUNTRY)<br><b>TENNESSEE</b>                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                                                                                            |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.                                         |                                                                 |                                                                                                                               |                                                 |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>KENSON NURSING HOME</b> |                                                                        |                                                                                                                                                             |                                                               | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CHAUFFEUR</b>            |                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>LONGSHORE</b>                                                                         |                                                 |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY                                                                                                                             |                                                                        | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                       |                                                               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                 | 13e. STREET ADDRESS<br><b>747 DRUID HILL PARK DRIVE</b>                                                                       |                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOSEPH ROBINSON</b>                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                         |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mollie Robinson</b>                                                                                     |                                                               |                                                                                                 |                                                                 |                                                                                                                               |                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>                                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>UNKNOWN</b>                                                               |                                                                        | 17. INFORMANT<br><b>CARRIE ROBINSON</b>                                                                                                                     |                                                               | ADDRESS<br><b>6377 DRUID LAKE DRIVE</b>                                                         |                                                                 |                                                                                                                               |                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>M.I. (Myocardial infarction).</b><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Generalized Arteriosclerosis, Hypertension.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Senile Change, C.I.A.</b><br>prior Heart Condition. |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                               |                                                                                                 |                                                                 |                                                                                                                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Urinary tract infection, C.O.P.D.</b>                                                                                                                                                                                          |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                               |                                                                                                 |                                                                 |                                                                                                                               |                                                 |
| 19a. DATE OF OPERATION<br><b>—</b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>           |                                                                                                                                                             |                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                                 | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                  |  |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |                                                                                                                                                             |                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                   |                                                                 |                                                                                                                               |                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                              |  |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                 |                                                                                                                               |                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>August 5, 19 80</b> to <b>Sept 29, 19 82</b> that (I) (we) lost<br>saw the deceased alive on <b>Sept 27, 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (and not) view the body after death.                    |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                               |                                                                                                 |                                                                 |                                                                                                                               |                                                 |
| 22b. SIGNATURE<br><b>Schue-Yuan Liao, M.D.</b>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                               | DEGREE<br><b>MD</b>                                                                             |                                                                 | 22c. DATE SIGNED<br><b>9/29/82</b>                                                                                            |                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Schue-Yuan Liao, M.D.</b>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                               | 22e. ADDRESS<br><b>Rm 215 Olsen Med Center<br/>7600 Olsen Dr. Towson, Md. 21204</b>             |                                                                 |                                                                                                                               |                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                         | 23b. DATE<br><b>10/4/82</b>                                            |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial</b> |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus Md</b> |                                                                                                                               |                                                 |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Rm e. Havel</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                               | ADDRESS<br><b>F/H 1101 E. North Ave</b>                                                         |                                                                 | 25a. DATE RECEIVED BY REGISTRAR<br><b>SEP 30 1982</b>                                                                         |                                                 |
|                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                               | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Smith</b>                                              |                                                                 |                                                                                                                               |                                                 |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 4 2 8

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                               |                                                                                                                                                 |                                                                                                                                                            |                                                                  |                                                                        |                                                                                                 |  |
|---------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Theodore (THEORE) ROBINSON</b>                                      |                                                                                                                                                 |                                                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09 29 82</b>           |                                                                        | 2b. HOUR<br><b>12<sup>30</sup> A.M.</b>                                                         |  |
| 3 SEX<br><b>male</b>                                                                                          | 4 RACE<br><b>Black</b>                                                                                                                          | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 10 10<sup>8</sup></b>                                                                                          | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.                |                                                                        | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. Carolina</b>                                               | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                      | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD. |                                                                        |                                                                                                 |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE UNION MEMORIAL HOSPITAL</b> |                                                                                                                                                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                        | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |  |
| 13a. STATE<br><b>Maryland</b>                                                                                 |                                                                                                                                                 | 13b. COUNTY                                                                                                                                                | 13c. CITY OR TOWN<br><b>Baltimore</b>                            |                                                                        | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Preston Robinson,</b>                                             |                                                                                                                                                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lizzie McLaughlin</b>                                                                                  |                                                                  |                                                                        |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b> |                                                                                                                                                 | 16b. SOCIAL SECURITY NO.<br><b>231-09-4571</b>                                                                                                             |                                                                  | 17 INFORMANT ADDRESS<br><b>Almita S.R. Woods 122 Melody Lane 28540</b> |                                                                                                 |  |

|                                                                                                                                                                                                                                                                                |  |                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ventricular Arrhythmia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Chronic Renal Failure - Chronic Obstr. Pulm. Disease - Diabetes mellitus</b>                                                        |  |                                                 |

|                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                        |  |                                                                                      |  |                                                                                                                               |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |                                                                                                                               |  |
| 22a. I certify that (I) this hospital attended the deceased from <b>9/19</b> , 19 <b>82</b> , to <b>9/29</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>9/28</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (yes) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                      |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><b>Robert A. Miller MD</b>                                                                                                                                                                                                                                                                                                                      |  |                                                                        |  | DEGREE<br><b>MD</b>                                                                  |  | 22c. DATE SIGNED<br><b>9/29/82</b>                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert A. Miller MD</b>                                                                                                                                                                                                                                                                                               |  |                                                                        |  | 22e. ADDRESS<br><b>Union Mem Hospital</b>                                            |  |                                                                                                                               |  |

|                                                               |  |                             |  |                                                                 |  |                                                                  |  |
|---------------------------------------------------------------|--|-----------------------------|--|-----------------------------------------------------------------|--|------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b> |  | 23b. DATE<br><b>10/ /82</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion Bapt. Ch.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Eastover S.</b> |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>W.C. March</b>              |  |                             |  | ADDRESS<br><b>F/H 1101 E. North Avenue</b>                      |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 30 1982</b>              |  |

25b. REGISTRAR'S SIGNATURE  
*[Signature]*

Handwritten notes on lined paper, including a date stamp "NOV 19 1960" and a circular stamp with the text "U.S. DEPT. OF JUSTICE".



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                      |  | 8 2 2 3 4 2 9                                                                                                                                            |  |                                                                                                                         |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                      |  | REG. NO.                                                                                                                                                 |  |                                                                                                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>MARIE E. ROKOS</b>                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                      |  | 2a. DATE OF DEATH <b>MON 9-8-82</b>                                                                                                                      |  | 2b. HOUR <b>5</b> M                                                                                                     |  |
| 3. SEX <b>Female</b>                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE <b>Cauc.</b>                                                                                                                 |  | 5. DATE OF BIRTH <b>8 4 93</b>                                                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS                                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>                                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>                                                                                             |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.                                                             |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mayfield Senior Center</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Saleslady</b>                                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Retail Hat Business</b>                                                            |  |
| 13a. STATE <b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                       |  | 13b. COUNTY <b>-</b>                                                                                                                 |  | 13c. CITY OR TOWN <b>Baltimore</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) <b>Joseph Klecka</b>                                                                                                                                                                                                                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Marie Hranicka</b>                                                                   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>                                                                              |  |                                                                                                                         |  |
| 16b. SOCIAL SECURITY NO. <b>220-12-2866</b>                                                                                                                                                                                                                                                                                                                                                 |  | 17. INFORMANT <b>Michael Rokos (grandson)</b>                                                                                        |  | 17. ADDRESS <b>Joppa, Md.</b>                                                                                                                            |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>ASCVD</b><br><b>4292</b> IMMEDIATE CAUSE (a) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>several yrs.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>lost</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>lost</b> |  |                                                                                                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>several yrs.</b>                                                                                         |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                         |  |                                                                                                                                      |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                     |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                          |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>                                                                               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-26-77</b> to <b>9-8-82</b> , that (I) (we) lost the deceased alive on <b>9-8-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                      |  |                                                                                                                                      |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 22b. SIGNATURE <b>E. Ellsworth Cook MD</b>                                                                                                                                                                                                                                                                                                                                                  |  | DEGREE <b>MD</b>                                                                                                                     |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED <b>9-9-82</b>                                                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E. Ellsworth Cook MD</b>                                                                                                                                                                                                                                                                                                                           |  | 22e. ADDRESS <b>2431 Maryland Ave. Balto. Md.</b>                                                                                    |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>                                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE <b>9/10/82</b>                                                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Crematory</b>                                                                                           |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>                                                               |  |
| 24. FUNERAL DIRECTOR NAME <b>Chrimunek Funeral Home, Inc.</b>                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                      |  | 25a. DATE REC'D. BY REGISTRAR <b>SEP 10 1982</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Lauer</b>                                                                         |  |
| 3331 Brehms Lane, Balto. Md. 21213                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                      |  |                                                                                                                                                          |  |                                                                                                                         |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 4 3 0

REG. NO.

FOR  
1. STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                        |                                                                        |                                                                                                                                                             |                                                             |                                                                                                                                           |                                                                                                 |                                                                                                                            |                                           |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Clarence Dudley ROSE                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                        | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>September 21, 1982              |                                                                                                                                                             |                                                             | 2b. HOUR<br>12:50p <sub>M</sub>                                                                                                           |                                                                                                 |                                                                                                                            |                                           |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br>WHITE                                                                                                                       |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1/26/1905                                                                                                             |                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.                                                                                                |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTO., MD.                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                 |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                                |                                                                                                 |                                                                                                                            |                                           |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |                                                                        |                                                                                                                                                             |                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SELF-EMPLOYED                                                         |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>FINE PRINTING                                                                         |                                           |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                        | 13b. COUNTY<br>-----                                                   |                                                                                                                                                             | 13c. CITY OR TOWN<br>Baltimore                              |                                                                                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS<br>4 UPLAND RD. 21210 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>CHARLES DUDLEY ROSE                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SUE JEFFRIES          |                                                                                                                                                             |                                                             |                                                                                                                                           |                                                                                                 |                                                                                                                            |                                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                        | 16b. SOCIAL SECURITY NO.<br>212.03.1871                                |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br>WILHELMINA D. ROSE SAME AS 13e. |                                                                                                                                           |                                                                                                 |                                                                                                                            |                                           |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease with</u><br><u>1991</u> <del>XXXXXX</del> recent myocardial and congestive<br>heart failure; pyelonephritis<br>(b) <u>Metastatic carcinoma, primary site unclear</u><br>(c) <u>Metastatic carcinoma, primary site unclear</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                        |                                                                        |                                                                                                                                                             |                                                             |                                                                                                                                           |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |                                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                        |                                                                        |                                                                                                                                                             |                                                             |                                                                                                                                           |                                                                                                 |                                                                                                                            |                                           |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                             | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                      |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                            |                                                                                                 |                                                                                                                            |                                           |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                         |                                                                                                 |                                                                                                                            |                                           |  |
| 22a. I certify that (x) (his hospital) attended the deceased from <u>September 18</u> 19 <u>82</u> to <u>September 21</u> 19 <u>82</u> that (x) (we) last saw the deceased alive on <u>September 21</u> 19 <u>82</u> and that in (nx) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (not) view the body after death.                                                                                                                                  |  |                                                                                                                                        |                                                                        |                                                                                                                                                             |                                                             |                                                                                                                                           |                                                                                                 |                                                                                                                            |                                           |  |
| 22b. SIGNATURE<br><u>Jose Boston MD</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                        |                                                                        |                                                                                                                                                             |                                                             | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED                                                                                                           |                                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jose Boston, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                        |                                                                        |                                                                                                                                                             |                                                             | 22e. ADDRESS<br>c/o Maryland General Hospital                                                                                             |                                                                                                 |                                                                                                                            |                                           |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>CREMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                        | 23b. DATE<br>9/22/1982                                                 |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>GREEN MOUNT           |                                                                                                                                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD.                                        |                                                                                                                            |                                           |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                        |                                                                        |                                                                                                                                                             |                                                             | 25a. DATE REC'D. BY REGISTRAR<br>SEP 23 1982                                                                                              |                                                                                                 |                                                                                                                            |                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                        |                                                                        |                                                                                                                                                             |                                                             | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Carrol</u>                                                                                       |                                                                                                 |                                                                                                                            |                                           |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  | 8 2 2 3 4 3 1                                        |  |                                    |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------|--|------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | REG. NO.                                                                                                                           |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |                                                      |  |                                    |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Rebecca</i> FIRST MIDDLE LAST <i>Rosen</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    |  |                                                                                                                                                             |  | 2a. DATE OF DEATH MONTH DAY YEAR <i>9-20-82</i> 2b. HOUR <i>12:56p</i>               |  |                                                                                                                            |  |                                                      |  |                                    |  |
| 3. SEX <i>FEMALE</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE <i>WHITE</i>                                                                                                               |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>DEC. 10, 1891</i>                                                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>90</i> YRS                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |  |                                                      |  |                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>RUSSIA</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                                                         |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD                     |  |                                                                                                                            |  |                                                      |  |                                    |  |
| 10. CITY OR TOWN OF DEATH<br><i>BALTIMORE</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>SINAI HOSPITAL</i> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>HOUSEWIFE</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>AT HOME</i>                                                                        |  |                                                      |  |                                    |  |
| 13a. STATE <i>MARYLAND</i> 13b. COUNTY <i>BALTO.</i> 13c. CITY OR TOWN <i>BALTIMORE</i> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  | 13e. STREET ADDRESS<br><i>3218 SMITH AVE. #21208</i> |  |                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>SAMUEL ACKERMAN</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>FANNIE HAVELOCK</i>                                                                                     |  |                                                                                      |  |                                                                                                                            |  |                                                      |  |                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.<br><i>216-01-6556</i>                                                                                     |  | 17. INFORMANT<br><i>MRS. BEBE LEVIN</i>                                                                                                                     |  | <i>3218 SMITH AVE. BALTO., MD</i>                                                    |  | <i>21208</i>                                                                                                               |  |                                                      |  |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><i>4292</i> IMMEDIATE CAUSE (a) <i>Respiratory failure</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>COPD</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(c) <i>neurologic pulmonary disease</i><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>ASCUS i @ hyp Fracture</i> |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |  |                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                      |  |                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                                                                              |  |                                                                                      |  |                                                                                                                            |  |                                                      |  |                                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                             |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                      |  |                                                                                                                            |  |                                                      |  |                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                                         |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  | 22b. SIGNATURE<br><i>[Signature]</i> MD              |  | 22c. DATE SIGNED<br><i>9/20/82</i> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                    |  | 22e. ADDRESS<br><i>SINAI HOSP. - BALTO., MD</i>                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |                                                      |  |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <i>BURIAL</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br><i>SEPT. 21, 1982</i>                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>WORKMEN CIRCLE</i>                                                                                                 |  | 23d. LOCATION<br><i>BALTIMORE</i> COUNTY <i>MARYLAND</i>                             |  |                                                                                                                            |  |                                                      |  |                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME <i>SOL LEVINSON &amp; BROS., INC.</i> ADDRESS <i>6010 REISTERSTOWN RD. BALTO., MD 21215</i>                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                    |  | 25a. DATE RECEIVED BY REGISTRAR<br><i>SEP 23 1982</i>                                                                                                       |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                     |  |                                                                                                                            |  |                                                      |  |                                    |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

|                                                                                                 |  |                                                                                                                                             |                                                |                                                                                                                                                             |  |                                                                             |  |
|-------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JAMES WILMER ROSS                                        |  |                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9 11 82 |                                                                                                                                                             |  | 2b. HOUR<br>8:54 P.M.                                                       |  |
| 3. SEX<br>MALE                                                                                  |  | 4. RACE<br>WHITE                                                                                                                            |                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 22 1921                                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS                                   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                      |                                                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY MD.                     |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO.                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VAMC BALTIMORE, MARYLAND 21218 |                                                |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>TRUCK DRIVER                                               |  | 13a. STATE<br>MD.                                                                                                                           |                                                | 13b. COUNTY                                                                                                                                                 |  | 13c. CITY OR TOWN<br>BALTO.                                                 |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3023 FAIT AVE                                                                                                        |                                                | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>CHARLES ROSS                                                                                                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ETHEL OLIVER               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES                     |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>1211 216 09 1820                                                                 |                                                | 17. INFORMANT<br>ADDRESS<br>Lois Houck 816 S. LINWOOD AVE.                                                                                                  |  |                                                                             |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Large Cell Undifferentiated Carcinoma of Unknown Etiology 5 months

1991

CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.

(b) \_\_\_\_\_

DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

DUE TO, OR AS A CONSEQUENCE OF

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

## MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                        |  |                                                                                |  |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |                                                                                                                            |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>AUGUST 18</u> , 19 <u>82</u> , to <u>SEPTEMBER 11</u> , 19 <u>82</u> , that (X) (we) last saw the deceased alive on <u>SEPTEMBER 11</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>Howard Jacobs MD                                                                                                                                                                                                                                                                                                                                                      |  |                                                                        |  | DEGREE<br>MD                                                                   |  | 22c. DATE SIGNED<br>9/11/82                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HOWARD JACOBS MD                                                                                                                                                                                                                                                                                                                               |  |                                                                        |  | 22e. ADDRESS<br>LOCH RAVEN VA 3900 LOCH RAVEN BLVD 21218                       |  |                                                                                                                            |  |

|                                                          |  |                      |  |                                                                                     |  |                                                   |  |
|----------------------------------------------------------|--|----------------------|--|-------------------------------------------------------------------------------------|--|---------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(CPY)<br>BURIAL       |  | 23b. DATE<br>9-15-82 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>OAKLAND CEM.                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br>BALTO. MD |  |
| 24. FUNERAL DIRECTOR<br>HOFMANN-SKARDA FH 3215 HUDSON ST |  |                      |  | 25. DATE REC'D. BY REGISTRAR OF REGISTRAR'S SIGNATURE<br>SEP 14 1982 John J. Carver |  |                                                   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed and retained 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                            |  | 8 2 2 3 4 3 3                                                                                                              |  |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|--|--|
| FOR<br>1. STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | REG. NO.                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                            |  |                                                                                                                            |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARY JANE ROST</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                |  |                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>SEPTEMBER 02 1982</b>                                 |  |                                                                                                                                            |  | 2b. HOUR<br><b>03:30AM</b>                                                                                                 |  |  |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br><b>Caucasian</b>                                                                                                                    |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March, 14, 1932</b>                                                                                                |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>50</b> YRS                                                |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>                                                                                            |  | 7. IF UNDER 24 HRS<br>HOURS MIN.<br><b>0 0</b>                                                                             |  |  |  |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 8b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |                                                                                                                                            |  |                                                                                                                            |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |                                                                                                                                                             |  |                                                                                                 |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Library aide</b>                                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Library</b>                                                                        |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                      |  | 13b. COUNTY<br><b>Montgomery</b>                                                                                                               |  | 13c. CITY OR TOWN<br><b>Potomac</b>                                                                                                                         |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>8617 Bunnell Drive</b>                                                                                           |  |                                                                                                                            |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Dolan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Florence McLoughlin</b>                                                                                 |  |                                                                                                 |  |                                                                                                                                            |  |                                                                                                                            |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 16b. SOCIAL SECURITY NO.<br><b>215-52-5248</b>                                                                                                 |  | 17. INFORMANT<br>ADDRESS<br><b>John P. Rost (Husband) 8617 Bunnell Drive Potomac, Maryland 20854</b>                                                        |  |                                                                                                 |  |                                                                                                                                            |  |                                                                                                                            |  |  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>2050</b> IMMEDIATE CAUSE (a) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Renal Failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Acute Prostanolitic Ischemia</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 weeks</b><br><b>2 weeks</b><br><b>2 months</b> |  |                                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                            |  |                                                                                                                            |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>11</b>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                            |  |                                                                                                                            |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                                                                 |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |                                                                                                                                            |  |                                                                                                                            |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |  |                                                                                                                                            |  |                                                                                                                            |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/2</b> 19 <b>82</b> to <b>9/2</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>8/2</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                       |  |                                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                            |  |                                                                                                                            |  |  |  |
| 22b. SIGNATURE<br><b>Kenneth Marek</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                |  | DEGREE                                                                                                                                                      |  |                                                                                                 |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>9/2/82</b>                                                                                          |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kenneth Marek</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                |  | 22e. ADDRESS<br><b>Shas Hopkins Hwy</b>                                                                                                                     |  |                                                                                                 |  |                                                                                                                                            |  |                                                                                                                            |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial/entombment</b>                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><b>Sept. 7, 1982</b>                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven Cemetery</b>                                                                                        |  | LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Silver Spring, Montg., Md.</b>                      |  |                                                                                                                                            |  |                                                                                                                            |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Pumphrey Funeral Homes, P.A., 300 W. Montgomery Ave., Rockville, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 9 1982</b>                                                                                                          |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Cichewicz</b>                                          |  |                                                                                                                                            |  |                                                                                                                            |  |  |  |

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified about it.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                               |  |                                                                                             |  | REG. NO. 8 2 2 3 4 3 4                                                                                                                         |  |                                                                                                                         |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                             |  |                                                                                             |  |                                                                                                                                                |  |                                                                                                                         |                                              |
| 1. DECEASED NAME (TYPE OR PRINT) <b>MARY</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                                             |  | 2a. DATE OF DEATH MONTH <b>9</b> DAY <b>15</b> YEAR <b>82</b>                                                                                  |  |                                                                                                                         |                                              |
| 3. SEX <b>Female</b>                                                                                                                                                                                                                                                                                                                                               |  |                                                                                             |  | 2b. HOUR <b>11:30 AM</b>                                                                                                                       |  |                                                                                                                         |                                              |
| 4. RACE <b>White</b>                                                                                                                                                                                                                                                                                                                                               |  |                                                                                             |  | 5. DATE OF BIRTH MONTH <b>9</b> DAY <b>11</b> YEAR <b>1897</b>                                                                                 |  |                                                                                                                         |                                              |
| 6. BIRTHPLACE (STATE OF FOREIGN COUNTRY) <b>Maryland</b>                                                                                                                                                                                                                                                                                                           |  |                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.                                                                                                 |  |                                                                                                                         |                                              |
| 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                                                                                                                                                                                                                                                            |  |                                                                                             |  | 7a. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>                                                                                                |  |                                                                                                                         |                                              |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                           |  |                                                                                             |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                                                                                 |  |                                                                                                                         |                                              |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital</b>          |  |                                                                                                                         |                                              |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>house-wife</b>                                                                                                                                                                                                                                                                                    |  |                                                                                             |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>hpme</b>                                                                                                  |  |                                                                                                                         |                                              |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b></b>                                                                                                                                                                                     |  |                                                                                             |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>6741 Youngstown Avenue</b> |  |                                                                                                                         |                                              |
| 14. FATHER'S NAME FIRST <b>Michael</b> MIDDLE <b>Radziszewski</b> LAST <b></b>                                                                                                                                                                                                                                                                                     |  |                                                                                             |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Adamima</b> MIDDLE <b>Groczyński</b> LAST <b></b>                                                            |  |                                                                                                                         |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b> (IF YES, GIVE WAR OR DATES) <b></b>                                                                                                                                                                                                                                                    |  |                                                                                             |  | 16b. SOCIAL SECURITY NO. <b>213 74 5516</b>                                                                                                    |  |                                                                                                                         |                                              |
| 17. INFORMANT ADDRESS <b>Gracyan Rowny 6741 Youngstown Avenue 21222</b>                                                                                                                                                                                                                                                                                            |  |                                                                                             |  |                                                                                                                                                |  |                                                                                                                         |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> 5860                                                                                                                                                                                                               |  |                                                                                             |  |                                                                                                                                                |  |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>ADULT RESPIRATORY DISTRESS SYNDROME</b>                                                                                                                                                                                                                                                                                      |  |                                                                                             |  |                                                                                                                                                |  |                                                                                                                         | <b>1 month</b>                               |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>RENAL FAILURE</b>                                                                                                                                                                                                                                                                                                            |  |                                                                                             |  |                                                                                                                                                |  |                                                                                                                         | <b>1 month</b>                               |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>                                                                                                                                                                                                                           |  |                                                                                             |  |                                                                                                                                                |  |                                                                                                                         |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                            |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY HOUR <b></b> A.M. MONTH <b></b> DAY <b></b> YEAR <b>19</b> P.M. <b></b> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                  |  |                                                                                                                         |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                         |  | 21f. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>                                                                 |  |                                                                                                                         |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/21</b> , 19 <b>82</b> , to <b>9/15</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>9/15</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                             |  |                                                                                                                                                |  |                                                                                                                         |                                              |
| 22b. SIGNATURE <b>Richard A. Joseph MD</b> DEGREE <b>MD</b>                                                                                                                                                                                                                                                                                                        |  |                                                                                             |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>     |  | 22c. DATE SIGNED <b>9/15/82</b>                                                                                         |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RICHARD A JOSEPH</b>                                                                                                                                                                                                                                                                                                      |  |                                                                                             |  | 22e. ADDRESS <b>BALTIMORE CITY HOSPITAL</b>                                                                                                    |  |                                                                                                                         |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                            |  | 23b. DATE <b>9/18/1982</b>                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Of Mary</b>                                                                                 |  | 23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b></b> STATE <b>Md</b>                                              |                                              |
| 24. FUNERAL DIRECTOR NAME <b>Walter Dabrowski</b> ADDRESS <b>1005 Dundalk, Balto, Md 21224</b>                                                                                                                                                                                                                                                                     |  |                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR <b>SEP 20 1982</b> REGISTRAR'S SIGNATURE <b>[Signature]</b>                                                      |  |                                                                                                                         |                                              |

Walter Dabrowski 1005 Dandridge, Baltimore, Md 21218

Burial

9/18/1982 Sacred Heart of Mary

Baltimore

MD

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Dabrowski

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 4 3 5

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                     |  |                 |  |       |  |      |  |           |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|---------------------|--|-----------------|--|-------|--|------|--|-----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | FIRST                                                                                                     |  | MIDDLE                                                                                                                                                      |  | LAST                                                                |  | 2a. DATE OF DEATH   |  | MONTH           |  | DAY   |  | YEAR |  | 2b. HOUR  |  |
| STANLEY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                           |  |                                                                                                                                                             |  | ROZEK                                                               |  | 9-25-82             |  |                 |  |       |  |      |  | 1:55 A.M. |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE                                                                                                   |  | 5. DATE OF BIRTH                                                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR     |  | IF UNDER 24 HRS |  |       |  |      |  |           |  |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | White                                                                                                     |  | April 6, 1918                                                                                                                                               |  | 64                                                                  |  | MONTHS              |  | DAYS            |  | HOURS |  | MIN  |  |           |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                     |  |                 |  |       |  |      |  |           |  |
| Penna                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | U.S.A.                                                                                                    |  |                                                                                                                                                             |  | BALTIMORE CITY                                                      |  |                     |  |                 |  |       |  |      |  | MD.       |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                     |  |                 |  |       |  |      |  |           |  |
| BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | UNION MEMORIAL HOSPITAL                                                                                   |  | Retired Electrician                                                                                                                                         |  |                                                                     |  |                     |  |                 |  |       |  |      |  |           |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 13b. COUNTY                                                                                               |  | 13c. CITY OR TOWN                                                                                                                                           |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS |  |                 |  |       |  |      |  |           |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  | Baltimore                                                                                                                                                   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 826 W. 35th Street  |  |                 |  |       |  |      |  |           |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | MIDDLE                                                                                                    |  | LAST                                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME                                            |  | FIRST               |  | MIDDLE          |  | LAST  |  |      |  |           |  |
| late Stefan Rozek                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                           |  |                                                                                                                                                             |  | late unknown                                                        |  |                     |  |                 |  |       |  |      |  |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.                                                                                  |  | 17. INFORMANT                                                                                                                                               |  | ADDRESS                                                             |  |                     |  |                 |  |       |  |      |  |           |  |
| No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 212 09 4872                                                                                               |  | Mrs Edith Rozek                                                                                                                                             |  | 106 Rose St Timonium Md                                             |  |                     |  |                 |  |       |  |      |  |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>1991</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) <u>ANAPLASTIC CANCER</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                              |  |                                                                                                                                                             |  |                                                                     |  |                     |  |                 |  |       |  |      |  |           |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  | 20a. AUTOPSY?                                                                                                                                               |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                     |  |                 |  |       |  |      |  |           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                           |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                         |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                     |  |                 |  |       |  |      |  |           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                     |  |                     |  |                 |  |       |  |      |  |           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | P.M. 19                                                                                                   |  |                                                                                                                                                             |  |                                                                     |  |                     |  |                 |  |       |  |      |  |           |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET                                                                                                                                     |  | CITY OR TOWN                                                        |  | COUNTY              |  | STATE           |  |       |  |      |  |           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                     |  |                 |  |       |  |      |  |           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/20</u> 19 <u>82</u> , to <u>9/25</u> 19 <u>82</u> , that (I) (we) lost<br>saw the deceased alive on <u>9/24</u> 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) did (did not) view the body after death.                                                                                                                            |  | 22b. SIGNATURE<br><u>Robert Varipapa MD</u>                                                               |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><u>9/25/82</u>                                  |  |                     |  |                 |  |       |  |      |  |           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 22e. ADDRESS                                                                                              |  |                                                                                                                                                             |  |                                                                     |  |                     |  |                 |  |       |  |      |  |           |  |
| ROBERT VARIPAPA MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | UNION MEMORIAL HOSPITAL                                                                                   |  |                                                                                                                                                             |  |                                                                     |  |                     |  |                 |  |       |  |      |  |           |  |
| 23a. BURIAL, CREMATION, REMOVAL                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 23b. DATE                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  | 23d. LOCATION<br>CITY OR TOWN                                       |  | COUNTY              |  | STATE           |  |       |  |      |  |           |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | Sept 27, 1982                                                                                             |  | Garden of Faith                                                                                                                                             |  | Baltimore Maryland                                                  |  |                     |  |                 |  |       |  |      |  |           |  |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | ADDRESS                                                                                                   |  | 25a. DATE REC'D BY REGISTRAR                                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE                                          |  |                     |  |                 |  |       |  |      |  |           |  |
| Harry H Witzke                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 4112 Columbia Rd Ellicott City                                                                            |  | SEP 28 1982                                                                                                                                                 |  | <u>[Signature]</u>                                                  |  |                     |  |                 |  |       |  |      |  |           |  |



122

9-22-25

April 1, 1913

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 4 3 6  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                  |                                                                                                                                                             |                                                                               |                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Rose Rubin                                                                                                                                                                                                                                                                                                          |                                                                                                                                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9/10/82                                                                                                              |                                                                               | 2b. HOUR<br>11:45<br>M                                                                                                     |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                           | 4. RACE<br>WHITE                                                                                                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10/2/95                                                                                                               |                                                                               | 6. AGE (IN YEARS, LAST BIRTHDAY)<br>86<br>YRS. MONTHS DAYS HOURS MIN.                                                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Russia                                                                                                                                                                                                                                                                                                        | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                                                 |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>HEMACOST N.H. Reg'd |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME                                                                               |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                  | 13b. COUNTY<br>BALTIMORE                                                                                                                                    | 13c. CITY OR TOWN<br>BALTIMORE                                                |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOSEPH SPETNER                                                                                                                                                                                                                                                                                                   |                                                                                                                                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>BESSIE UNKNOWN                                                                                             |                                                                               |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                 |                                                                                                                                  | 16b. SOCIAL SECURITY NO.<br>215-09-2699                                                                                                                     |                                                                               | 17. INFORMANT<br>MRS. HILDA STEWART<br>2320 PENNYROYAL TERRACE<br>812 Foxglove<br>21209                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4292 Cardiac Arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) Generalized ASCVD<br>DUE TO, OR AS A CONSEQUENCE OF (c) Sudden<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                                                                                                                  |                                                                                                                                                             |                                                                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2+ yrs                                                                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                        |                                                                                                                                  |                                                                                                                                                             |                                                                               |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                    |                                                                                                                                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK                                                                                                                                                                                                                                                       |                                                                                                                                  | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                               | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                          |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/10/82 to 9/11/82 that (I) (we) last saw the deceased alive on 9/10/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If last related did not view the body after death)                                                        |                                                                                                                                  |                                                                                                                                                             |                                                                               |                                                                                                                            |
| 22b. SIGNATURE<br>Charles O'Donnell                                                                                                                                                                                                                                                                                                                        |                                                                                                                                  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                                                                               | 22c. DATE SIGNED<br>9/11/82                                                                                                |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Charles O'Donnell                                                                                                                                                                                                                                                                                                 |                                                                                                                                  | 22e. ADDRESS<br>7501 YORK RD BALTIMORE MD 21209                                                                                                             |                                                                               |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                        | 23b. DATE<br>SEPT. 12, 1982                                                                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br>HEBREW YOUNG MENS CEM                                                                                                 |                                                                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND                                                           |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS. INC.<br>ADDRESS 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215                                                                                                                                                                                                                                          |                                                                                                                                  | 25. DATE REC'D BY REGISTRAR (SEE REGISTRAR'S SIGNATURE)<br>SEP 15 1982                                                                                      |                                                                               |                                                                                                                            |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   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| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Margaret S. Rucks                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    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DATE OF DEATH<br>MONTH DAY YEAR<br>9 25 82                                                  |                                |                                            |                               |  | 2b. HOUR<br>M |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4. RACE<br>Black                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 14 18                                                                                    |                                                                                                                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS               |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS |                                            | IF UNDER 24 HRS<br>HOURS MIN. |  |               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ark.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA |                                                                                                                                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |                                |                                            |                               |  |               |
| 10. CITY OR TOWN OF DEATH<br>Balto.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3123 Belmont Avenue |                                                                                                                                                             |                                                         | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |                                | 12b. KIND OF BUSINESS OR INDUSTRY          |                               |  |               |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Md. 13b. COUNTY 13c. CITY OR TOWN Balto.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      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INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                | 13e. STREET ADDRESS<br>3123 Belmont Avenue |                               |  |               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Scott                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       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MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Susie Ames                                                                                                 |                                                         |                                                                                                 |                                |                                            |                               |  |               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                     | 16b. SOCIAL SECURITY NO.<br>219-18-9932                                                                                          |                                                                                                                                                             | 17. INFORMANT ADDRESS<br>Mack K. Rucks 3123 Belmont Ave |                                                                                                 |                                |                                            |                               |  |               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (b), (c), (d), (e), (f), (g), (h), (i), (j), (k), (l), (m), (n), (o), (p), (q), (r), (s), (t), (u), (v), (w), (x), (y), (z), (aa), (ab), (ac), (ad), (ae), (af), (ag), (ah), (ai), (aj), (ak), (al), (am), (an), (ao), (ap), (aq), (ar), (as), (at), (au), (av), (aw), (ax), (ay), (az), (ba), (bb), (bc), (bd), (be), (bf), (bg), (bh), (bi), (bj), (bk), (bl), (bm), (bn), (bo), (bp), (bq), (br), (bs), (bt), (bu), (bv), (bw), (bx), (by), (bz), (ca), (cb), (cc), (cd), (ce), (cf), (cg), (ch), (ci), (cj), (ck), (cl), (cm), (cn), (co), (cp), (cq), (cr), (cs), (ct), (cu), (cv), (cw), (cx), (cy), (cz), (da), (db), (dc), (dd), (de), (df), (dg), (dh), (di), (dj), (dk), (dl), (dm), (dn), (do), (dp), (dq), (dr), (ds), (dt), (du), (dv), (dw), (dx), (dy), (dz), (ea), (eb), (ec), (ed), (ee), (ef), (eg), (eh), (ei), (ej), (ek), (el), (em), (en), (eo), (ep), (eq), (er), (es), (et), (eu), (ev), (ew), (ex), (ey), (ez), (fa), (fb), (fc), (fd), (fe), (ff), (fg), (fh), (fi), (fj), (fk), (fl), (fm), (fn), (fo), (fp), (fq), (fr), (fs), (ft), (fu), (fv), (fw), (fx), (fy), (fz), (ga), (gb), (gc), (gd), (ge), (gf), (gg), (gh), (gi), (gj), (gk), (gl), (gm), (gn), (go), (gp), (gq), (gr), (gs), (gt), (gu), (gv), (gw), (gx), (gy), (gz), (ha), (hb), (hc), (hd), (he), (hf), (hg), (hh), (hi), (hj), (hk), (hl), (hm), (hn), (ho), (hp), (hq), (hr), (hs), (ht), (hu), (hv), (hw), (hx), (hy), (hz), (ia), (ib), (ic), (id), (ie), (if), (ig), (ih), (ii), (ij), (ik), (il), (im), (in), (io), (ip), (iq), (ir), (is), (it), (iu), (iv), (iw), (ix), (iy), (iz), (ja), (jb), (jc), (jd), (je), (jf), (jg), (jh), (ji), (jj), (jk), (jl), (jm), (jn), (jo), (jp), (jq), (jr), (js), (jt), (ju), (jv), (jw), (jx), (jy), (jz), (ka), (kb), (kc), (kd), (ke), (kf), (kg), (kh), (ki), (kj), (kk), (kl), (km), (kn), (ko), (kp), (kq), (kr), (ks), (kt), (ku), (kv), (kw), (kx), (ky), (kz), (la), (lb), (lc), (ld), (le), (lf), (lg), (lh), (li), (lj), (lk), (ll), (lm), (ln), (lo), (lp), (lq), (lr), (ls), (lt), (lu), (lv), (lw), (lx), (ly), (lz), (ma), (mb), (mc), (md), (me), (mf), (mg), (mh), (mi), (mj), (mk), (ml), (mm), (mn), (mo), (mp), (mq), (mr), (ms), (mt), (mu), (mv), (mw), (mx), (my), (mz), (na), (nb), (nc), (nd), (ne), (nf), (ng), (nh), (ni), (nj), (nk), (nl), (nm), (nn), (no), (np), (nq), (nr), (ns), (nt), (nu), (nv), (nw), (nx), (ny), (nz), (oa), (ob), (oc), (od), (oe), (of), (og), (oh), (oi), (oj), (ok), (ol), (om), (on), (oo), (op), (oq), (or), (os), (ot), (ou), (ov), (ow), (ox), (oy), (oz), (pa), (pb), (pc), (pd), (pe), (pf), (pg), (ph), (pi), (pj), (pk), (pl), (pm), (pn), (po), (pp), (pq), (pr), (ps), (pt), (pu), (pv), (pw), (px), (py), (pz), (qa), (qb), (qc), (qd), (qe), (qf), (qg), (qh), (qi), (qj), (qk), (ql), (qm), (qn), (qo), (qp), (qq), (qr), (qs), (qt), (qu), (qv), (qw), (qx), (qy), (qz), (ra), (rb), (rc), (rd), (re), (rf), (rg), (rh), (ri), (rj), (rk), (rl), (rm), (rn), (ro), (rp), (rq), (rr), (rs), (rt), (ru), (rv), (rw), (rx), (ry), (rz), (sa), (sb), (sc), (sd), (se), (sf), (sg), (sh), (si), (sj), (sk), (sl), (sm), (sn), (so), (sp), (sq), (sr), (ss), (st), (su), (sv), (sw), (sx), (sy), (sz), (ta), (tb), (tc), (td), (te), (tf), (tg), (th), (ti), (tj), (tk), (tl), (tm), (tn), (to), (tp), (tq), (tr), (ts), (tt), (tu), (tv), (tw), (tx), (ty), (tz), (ua), (ub), (uc), (ud), (ue), (uf), (ug), (uh), (ui), (uj), (uk), (ul), (um), (un), (uo), (up), (uq), (ur), (us), (ut), (uu), (uv), (uw), (ux), (uy), (uz), (va), (vb), (vc), (vd), (ve), (vf), (vg), (vh), (vi), (vj), (vk), (vl), (vm), (vn), (vo), (vp), (vq), (vr), (vs), (vt), (vu), (vv), (vw), (vx), (vy), (vz), (wa), (wb), (wc), (wd), (we), (wf), (wg), (wh), (wi), (wj), (wk), (wl), (wm), (wn), (wo), (wp), (wq), (wr), (ws), (wt), (wu), (wv), (ww), (wx), (wy), (wz), (xa), (xb), (xc), (xd), (xe), (xf), (xg), (xh), (xi), (xj), (xk), (xl), (xm), (xn), (xo), (xp), (xq), (xr), (xs), (xt), (xu), (xv), (xw), (xx), (xy), (xz), (ya), (yb), (yc), (yd), (ye), (yf), (yg), (yh), (yi), (yj), (yk), (yl), (ym), (yn), (yo), (yp), (yq), (yr), (ys), (yt), (yu), (yv), (yw), (yx), (yy), (yz), (za), (zb), (zc), (zd), (ze), (zf), (zg), (zh), (zi), (zj), (zk), (zl), (zm), (zn), (zo), (zp), (zq), (zr), (zs), (zt), (zu), (zv), (zw), (zx), (zy), (zz), (aa), (ab), (ac), (ad), (ae), (af), (ag), (ah), (ai), (aj), (ak), (al), (am), (an), (ao), (ap), (aq), (ar), (as), (at), (au), (av), (aw), (ax), (ay), (az), (ba), (bb), (bc), (bd), (be), (bf), (bg), (bh), (bi), (bj), (bk), (bl), (bm), (bn), (bo), (bp), (bq), (br), (bs), (bt), (bu), (bv), (bw), (bx), (by), (bz), (ca), (cb), (cc), (cd), (ce), (cf), (cg), (ch), (ci), (cj), (ck), (cl), (cm), (cn), (co), (cp), (cq), (cr), (cs), (ct), (cu), (cv), (cw), (cx), (cy), (cz), (da), (db), (dc), (dd), (de), (df), (dg), (dh), (di), (dj), (dk), (dl), (dm), (dn), (do), (dp), (dq), (dr), (ds), (dt), (du), (dv), (dw), (dx), (dy), (dz), (ea), (eb), (ec), (ed), (ee), (ef), (eg), (eh), (ei), (ej), (ek), (el), (em), (en), (eo), (ep), (eq), (er), (es), (et), (eu), (ev), (ew), (ex), (ey), (ez), (fa), (fb), (fc), (fd), (fe), (ff), (fg), (fh), (fi), (fj), (fk), (fl), (fm), (fn), (fo), (fp), (fq), (fr), (fs), (ft), (fu), (fv), (fw), (fx), (fy), (fz), (ga), (gb), (gc), (gd), (ge), (gf), (gg), (gh), (gi), (gj), (gk), (gl), (gm), (gn), (go), (gp), (gq), (gr), (gs), (gt), (gu), (gv), (gw), (gx), (gy), (gz), (ha), (hb), (hc), (hd), (he), (hf), (hg), (hh), (hi), (hj), (hk), (hl), (hm), (hn), (ho), (hp), (hq), (hr), (hs), (ht), (hu), (hv), (hw), (hx), (hy), (hz), (ia), (ib), (ic), (id), (ie), (if), (ig), (ih), (ii), (ij), (ik), (il), (im), (in), (io), (ip), (iq), (ir), (is), (it), (iu), (iv), (iw), (ix), (iy), (iz), (ja), (jb), (jc), (jd), (je), (jf), (jg), (jh), (ji), (jj), (jk), (jl), (jm), (jn), (jo), (jp), (jq), (jr), (js), (jt), (ju), (jv), (jw), (jx), (jy), (jz), (ka), (kb), (kc), (kd), (ke), (kf), (kg), (kh), (ki), (kj), (kk), (kl), (km), (kn), (ko), (kp), (kq), (kr), (ks), (kt), (ku), (kv), (kw), (kx), (ky), (kz), (la), (lb), (lc), (ld), (le), (lf), (lg), (lh), (li), (lj), (lk), (ll), (lm), (ln), (lo), (lp), (lq), (lr), (ls), (lt), (lu), (lv), (lw), (lx), (ly), (lz), (ma), (mb), (mc), (md), (me), (mf), (mg), (mh), (mi), (mj), (mk), (ml), (mm), (mn), (mo), (mp), (mq), (mr), (ms), (mt), (mu), (mv), (mw), (mx), (my), (mz), (na), (nb), (nc), (nd), (ne), (nf), (ng), (nh), (ni), (nj), (nk), (nl), (nm), (nn), (no), (np), (nq), (nr), (ns), (nt), (nu), (nv), (nw), (nx), (ny), (nz), (oa), (ob), (oc), (od), (oe), (of), (og), (oh), (oi), (oj), (ok), (ol), (om), (on), (oo), (op), (oq), (or), (os), (ot), (ou), (ov), (ow), (ox), (oy), (oz), (pa), (pb), (pc), (pd), (pe), (pf), (pg), (ph), (pi), (pj), (pk), (pl), (pm), (pn), (po), (pp), (pq), (pr), (ps), (pt), (pu), (pv), (pw), (px), (py), (pz), (qa), (qb), (qc), (qd), (qe), (qf), (qg), (qh), (qi), (qj), (qk), (ql), (qm), (qn), (qo), (qp), (qq), (qr), (qs), (qt), (qu), (qv), (qw), (qx), (qy), (qz), (ra), (rb), (rc), (rd), (re), (rf), (rg), (rh), (ri), (rj), (rk), (rl), (rm), (rn), (ro), (rp), (rq), (rr), (rs), (rt), (ru), (rv), (rw), (rx), (ry), (rz), (sa), (sb), (sc), (sd), (se), (sf), (sg), (sh), (si), (sj), (sk), (sl), (sm), (sn), (so), (sp), (sq), (sr), (ss), (st), (su), (sv), (sw), (sx), (sy), (sz), (ta), (tb), (tc), (td), (te), (tf), (tg), (th), (ti), (tj), (tk), (tl), (tm), (tn), (to), (tp), (tq), (tr), (ts), (tt), (tu), (tv), (tw), (tx), (ty), (tz), (ua), (ub), (uc), (ud), (ue), (uf), (ug), (uh), (ui), (uj), (uk), (ul), (um), (un), (uo), (up), (uq), (ur), (us), (ut), (uu), (uv), (uw), (ux), (uy), (uz), (va), (vb), (vc), (vd), (ve), (vf), (vg), (vh), (vi), (vj), (vk), (vl), (vm), (vn), (vo), (vp), (vq), (vr), (vs), (vt), (vu), (vv), (vw), (vx), (vy), (vz), (wa), (wb), (wc), (wd), (we), (wf), (wg), (wh), (wi), (wj), (wk), (wl), (wm), (wn), (wo), (wp), (wq), (wr), (ws), (wt), (wu), (wv), (ww), (wx), (wy), (wz), (xa), (xb), (xc), (xd), (xe), (xf), (xg), (xh), (xi), (xj), (xk), (xl), (xm), (xn), (xo), (xp), (xq), (xr), (xs), (xt), (xu), (xv), (xw), (xx), (xy), (xz), (ya), (yb), (yc), (yd), (ye), (yf), (yg), (yh), (yi), (yj), (yk), (yl), (ym), (yn), (yo), (yp), (yq), (yr), (ys), (yt), (yu), (yv), (yw), (yx), (yy), (yz), (za), (zb), (zc), (zd), (ze), (zf), (zg), (zh), (zi), (zj), (zk), (zl), (zm), (zn), (zo), (zp), (zq), (zr), (zs), (zt), (zu), (zv), (zw), (zx), (zy), (zz)) |                                     |                                                                                                                                  |                                                                                                                                                             |                                                         |                                                                                                 |                                |                                            |                               |  |               |

Director of the  
Bureau of  
Prisons

RECEIVED  
JAN 15 1910  
U.S. DEPT. OF JUSTICE  
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                   |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                 |  | 7 2 2 3 4 3 8<br>REG. NO.                                                                                                            |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>MARY B. SABINE                                                                                                                                                                                                                                                |  |                                                                                                                                      |  |                                                                                                                                                             |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>9 29 82                                                     |  | 2b. HOUR<br>11:57 P M                                                                                                      |  |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br>WHITE                                                                                                                     |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 1, 1906                                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.                                                      |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE, CITY MD.                                     |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>TEACHER                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOPKINS UNIVERSITY                                                                    |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                 |  | 13b. COUNTY                                                                                                                          |  | 13c. CITY OR TOWN<br>BALTIMORE                                                                                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>4412 WICKFORD ROAD                                                                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>BERNARD B. BECK                                                                                                                                                                                                                                                              |  |                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANNE C. CUSTER                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                             |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214 40 7064                                                               |  | 17. INFORMANT ADDRESS<br>MICHAEL MORGAN, BALTO., MD                                                                                                         |  |                                                                                                 |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4280 PROBABLE PULMONARY EMBOLI<br>DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                     |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                     |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                 |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                           |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                               |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                            |  |
| 22a. I certify that (s/he) (this hospital) attended the deceased from 9/22, 1982, to 9/29, 1982, that (s/he) lost<br>saw the deceased alive on 9/29, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>SILVANA RIGGATO JAGODA                                                                                                                                                                                                                                                                               |  |                                                                                                                                      |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |                                                                                                 |  | 22c. DATE SIGNED<br>9/29/82                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SILVANA RIGGATO JAGODA                                                                                                                                                                                                                                                        |  |                                                                                                                                      |  | 22e. ADDRESS<br>201 E. University Pkwy. Balto. 21218                                                                                                        |  |                                                                                                 |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                 |  | 23b. DATE<br>10/5/82                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ROSEDALE                                                                                                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>MARTINSBURG, W. VA                                |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME Henry W. Jenkins & Sons Co.<br>ADDRESS 4905 York Road Balto., MD 21212                                                                                                                                                                                                                    |  |                                                                                                                                      |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 1 - 1982                                                                                                               |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Conner                                                    |  |                                                                                                                            |  |

425 York Road E/110, W. 11-12  
Henry W. Jenkins & Son Co.  
Burlington, N. H. 05401  
ROSEDALE

MARTIN, J. W. V.

NO. 114 NO. 1054 MICHAEL MORGAN, BAL TO., MD.  
BERNARD E. DECK ANNE C. CUSTER  
MAY AND E. W. TIM RE  
TEACHER UNIVERSITY  
WICKFORD ROAD  
MAY 1963

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                  |  |                  |                                                                                                                                       |                                                                        |                                                         |                                                                                                                                                             |                                                                                                 |                                                          |                                                             | REG. NO. 2 2 3 4 3 9                                                                |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Farid (nmi) Sadeghi                                                                                                                                                                                                                                                                                                                                                             |  |                  |                                                                                                                                       |                                                                        |                                                         | 7a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>9 17 1982                                                        |                                                                                                 | 7b. HOUR<br>M<br>9:50                                    |                                                             |                                                                                     |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br>WHITE |                                                                                                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3/21/1950                        |                                                         | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) MONTHS DAYS<br>32 YRS.                                                                                                 |                                                                                                 | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN                  |                                                             | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>9 17 1982                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>IRAN                                                                                                                                                                                                                                                                                                                                                                                        |  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>RESIDENT ALIEN                                                                                        |                                                                        |                                                         | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 |                                                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD. |                                                                                     |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                   |  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2400 blk. Sinclair Lane |                                                                        |                                                         |                                                                                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>DRIVER                         |                                                          | 12b. KIND OF BUSINESS OR INDUSTRY<br>TRANSPORTATION         |                                                                                     |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                  | 13b. COUNTY<br>-----                                                                                                                  |                                                                        | 13c. CITY OR TOWN<br>BALTIMORE                          |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                          | 13e. STREET ADDRESS<br>1522 MT. ROYAL AVE. 21217            |                                                                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNKNOWN                                                                                                                                                                                                                                                                                                                                                                                        |  |                  |                                                                                                                                       |                                                                        |                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNKNOWN                                                                                                    |                                                                                                 |                                                          |                                                             |                                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                              |  |                  |                                                                                                                                       | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212.84.6787 |                                                         | 17. INFORMANT<br>ADDRESS<br>1837 CROFTON PKWY.<br>DEBORAH S. SADEGHI APT. E.                                                                                |                                                                                                 |                                                          |                                                             |                                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 9650 Gunshot Wound of Head (Handgun)<br>CROFTON, MD. 21114<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                |  |                  |                                                                                                                                       |                                                                        |                                                         |                                                                                                                                                             |                                                                                                 |                                                          |                                                             |                                                                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                       |  |                  |                                                                                                                                       |                                                                        |                                                         |                                                                                                                                                             |                                                                                                 |                                                          |                                                             |                                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                  |                                                                                                                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                      |                                                         |                                                                                                                                                             |                                                                                                 |                                                          |                                                             | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                           |  |                  |                                                                                                                                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. 9 17 1982    |                                                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject shot by assailant                                                  |                                                                                                 |                                                          |                                                             |                                                                                     |  |
| 21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                     |  |                  |                                                                                                                                       | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>auto    |                                                         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>2400 blk. Sinclair Lane, Baltimore, Maryland                                                           |                                                                                                 |                                                          |                                                             |                                                                                     |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |                                                                                                                                       |                                                                        |                                                         |                                                                                                                                                             |                                                                                                 |                                                          |                                                             |                                                                                     |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>                                                                                                                                                                                                                                                                                                                                                                                               |  |                  |                                                                                                                                       | TITLE (SPECIFY)<br>M.D. Assistant                                      |                                                         |                                                                                                                                                             |                                                                                                 | DATE SIGNED<br>9-18-82                                   |                                                             |                                                                                     |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Dennis F. Smyth, M.D.                                                                                                                                                                                                                                                                                                                                                                              |  |                  |                                                                                                                                       | ADDRESS<br>111 Penn Street                                             |                                                         |                                                                                                                                                             |                                                                                                 |                                                          |                                                             |                                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                   |  |                  | 23b. DATE<br>9/24/1982                                                                                                                |                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br>OAK LAWN CEMETERY |                                                                                                                                                             |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD. |                                                             |                                                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222                                                                                                                                                                                                                                                                                                                                                   |  |                  |                                                                                                                                       |                                                                        |                                                         | 25a. DATE REC'D. BY REGISTRAR<br>SEP 23 1982                                                                                                                |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Connel</i>      |                                                             |                                                                                     |  |

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17 17 17





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                            |  | 8 2 2 3 4 4 0<br>REG. NO.                                                                                                                                   |  |                                                                                                                         |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                            |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR                                                                                                                   |  |                                                                                                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>PETRO - SAMUTYN                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                            |  | September 14, 1982 M                                                                                                                                        |  |                                                                                                                         |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br>White                                                                                                           |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>November 25, 1897                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br>84                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ukraine                                                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br>Ukraine                                                                                    |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                              |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6008 Carter Ave. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Soldier                                                                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Military                                                                           |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                            |  | 13b. COUNTY<br>-                                                                                                                                            |  | 13c. CITY OR TOWN<br>Baltimore                                                                                          |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Izot - Samutyn                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                            |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Maria - Mosklenko                                                                                             |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO -                                                                                                                                                                                                                                                                                                                |  |                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br>072-30-7561                                                                                                                     |  | 17. INFORMANT ADDRESS<br>Anna Samutyn 6008 Carter Ave. (21214)                                                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ca of the lungs &amp; metastasis</u><br>1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                            |  |                                                                                                                                                             |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic obstructive pulmonary disease</u>                                                                                                                                                                                                                                     |  |                                                                                                                            |  |                                                                                                                                                             |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                           |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                        |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>71</u> to <u>Sept 14</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>Sept 13</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                 |  |                                                                                                                            |  |                                                                                                                                                             |  |                                                                                                                         |  |
| 22b. SIGNATURE <u>Dr. Andrew Lemischka</u> DEGREE <u>MD</u>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                            |  | 22c. DATE SIGNED <u>9-15-82</u>                                                                                                                             |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Andrew Lemischka                                                           |  |
| 22e. ADDRESS<br>2608 E. Baltimore St.                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                            |  |                                                                                                                                                             |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br>Sept. 18, 82                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Andrews Uk. Orthodox                                                                                              |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>S. Boundbrook, N. Jersey                                                     |  |
| 24. FUNERAL DIRECTOR NAME<br>Lilly & Zeiler Inc. 1901 Eastern Ave.                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                            |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 17 1982                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br><u>J. A. G. Grist</u>                                                                     |  |



RELEASED AS NON MED BY DR DIXON OF THE MEDICAL  
EXAMINER'S OFFICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/B1  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                               |                                                                                                                                      |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                      |                                                                                                                            |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST J. 2 MIDDLE ELLA (McLaughlin) LAST SATTERFIELD                                                                                                                                                                                                                                                                                                           |                                                                                                                                      | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR<br>SEPTEMBER 21, 1982 07:15 PM                                                   |  |
| 3. SEX<br>Female c                                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE<br>Black                                                                                                                     | 5. DATE OF BIRTH MONTH DAY YEAR<br>11 10 18                                                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N. Carolina                                                                                                                                                                                                                                                                                                                                           | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.<br>64 YRS.                         |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD                                                                  |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Baltimore                                                                                                                                                                                                                                                          |                                                                                                                                      | 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>12c. KIND OF BUSINESS OR INDUSTRY                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>J. C. McMillian                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                      | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Minder McMillian                                                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                                                                                                                                                                                                                                                                                |                                                                                                                                      | 16b. SOCIAL SECURITY NO.<br>N/A                                                                                            |  |
| 17. INFORMANT ADDRESS<br>William McLaughlin 808 Bradhurst Rd                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                      |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cordial Arrest<br>4275<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>30 minutes |                                                                                                                                      |                                                                                                                            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.                                                                                                                                                                                                                                                                  |                                                                                                                                      |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                           |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                               |                                                                                                                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                 |                                                                                                                                      | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                    |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                                                                                                                                                                                                                                                                     |                                                                                                                                      |                                                                                                                            |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                             |                                                                                                                                      | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                        |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                      |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/21, 1982, to 9/21, 1982, that (I) (we) lost the deceased alive on 9/21, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                        |                                                                                                                                      |                                                                                                                            |  |
| 22b. SIGNATURE<br>Kenneth March                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                      | 22c. DATE SIGNED<br>9/21/82                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Kenneth March                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                      | 22e. ADDRESS<br>Johns Hopkins Hospital                                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                      | 23b. DATE<br>9/25/82                                                                                                       |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Church Cemetery                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                      | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Laurinburg N.C.                                                                 |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm. C. March F/H 1101 E. North Avenue                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                      | 25a. DATE REC'D. BY REGISTRAR<br>SEP 23 1982                                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                      | 25b. REGISTRAR'S SIGNATURE<br>John J. Connelley                                                                            |  |

MEDICAL CERTIFICATION

29

0000 BP

0 255 TP 13

DATE RECEIVED JULY 1958

100-100

RECEIVED JULY 1958

RECEIVED

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255 TP 13

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 2 2 3 4 4 2

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                          |                                                                  |                                                                                                                                                             |                                              |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EMMA M. SAUERMAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                          | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 28, 1982</b> |                                                                                                                                                             | 2b. HOUR<br><b>1:46p</b> M                   |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br><b>White</b>                                                                                                                                  |                                                                  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 18, 1898</b>                                                                                                   |                                              |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                                           |                                                                  | IF UNDER 24 HRS<br>HOURS MIN.                                                                                                                               |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                               |                                                                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                              |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                            |                                                                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b>               |                                              |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                                                                                                     |                                                                  | 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |                                              |  |
| 13b. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                    |                                                                  | 13e. STREET ADDRESS<br><b>501 W. Franklin Street</b>                                                                                                        |                                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John W. Bell</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret E. Springer</b>                                                                             |                                                                  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                               |                                              |  |
| 16b. SOCIAL SECURITY NO.<br><b>218 12 4519</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 17. INFORMANT ADDRESS<br><b>Edward E. Sauerman, Sr., Balto., MD</b>                                                                                      |                                                                  |                                                                                                                                                             |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>3499</b> IMMEDIATE CAUSE (a) <b>Cardiovascular collapse--Asystole</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Conduction system disease with refractory heart failure.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                                                                                        |  |                                                                                                                                                          |                                                                  |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                          |                                                                  |                                                                                                                                                             |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                                              |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                       |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |                                                                  |                                                                                                                                                             |                                              |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                           |                                                                  |                                                                                                                                                             |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                   |                                                                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                              |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>September 23, 1982</b> to <b>September 28, 1982</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>September 28, 1982</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death. |  |                                                                                                                                                          |                                                                  |                                                                                                                                                             |                                              |  |
| 22b. SIGNATURE<br><b>Michael Hyle</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | DEGREE<br><b>MD.</b>                                                                                                                                     |                                                                  | 22c. DATE SIGNED<br><b>9/28/82</b>                                                                                                                          |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael Hyle, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>                                                                                                     |                                                                  |                                                                                                                                                             |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br><b>10/1/82</b>                                                                                                                              |                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>                                                                                                    |                                              |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b><br><b>4905 York Road Balto., MD 21212</b>                                         |                                                                  |                                                                                                                                                             |                                              |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 30 1982</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                                                         |                                                                  |                                                                                                                                                             |                                              |  |

• **Chlorine**

612 21 612

Figure 3. *Continued*

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Environ Biol Fish (2015) 98:1111–1123

501 W. Franklin Street

Medical General Hospital

Exhibition 01

MAY 19 1961



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

item 6 #G572 10/27/82 ph

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2

2 3 4 4 3

REG. NO.

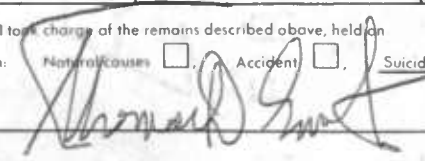

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Addie G. Savage                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                              |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9 28 82                                                                                                              |  | 2b. HOUR<br>1:40 am                                                                                                        |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br>Black                                                                                                                             |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 - 11 - 1901                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 X 80 YRS.                                                                            |  |
| 7a. BIRTHPLACE, (STATE OR FOREIGN COUNTRY)<br>Virginia                                                                                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                          |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.                                                                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Maryland Hospital |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>retired                                                |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>-----                                                                                                                                                                                                                                                                                                                                                                                   |  | 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                              |  | 13b. STREET ADDRESS<br>1105 N Mount Street                                                                                                                  |  |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Hiles                                                                                                                                                                                                                                                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Bessie unknown                                                                              |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                        |  |                                                                                                                            |  |
| 16b. SOCIAL SECURITY NO.<br>215-87-7094                                                                                                                                                                                                                                                                                                                                                                                      |  | 17. INFORMANT<br>Paul Savage                                                                                                                 |  |                                                                                                                                                             |  | ADDRESS<br>1105 N Mount St Baltimore                                                                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 6826 cardiac arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) 300515<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) cellulitis (Daa)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 days<br>1 week |  |                                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>NA                                                                                                                                                                                                                                                                                    |  |                                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION<br>NA                                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>NA                                                                                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>NA P.M. 19 82                                                                             |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>NA                                                                     |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>NA                                                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>NA Baltimore Maryland                                                                                  |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/28 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.                                                                                                                                                                                       |  |                                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>C Dimond                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                              |  | DEGREE<br>MD                                                                                                                                                |  | 22c. DATE SIGNED<br>9/28/82                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>C. Dimond                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                              |  | 22e. ADDRESS<br>University of Maryland Hospital                                                                                                             |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                       |  | 23b. DATE<br>10/4/82                                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King Mem Park                                                                                                         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                                           |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Law Funeral Home 4611 Park Heights Ave.                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 6 1982                                                                                                                 |  |                                                                                                                            |  |



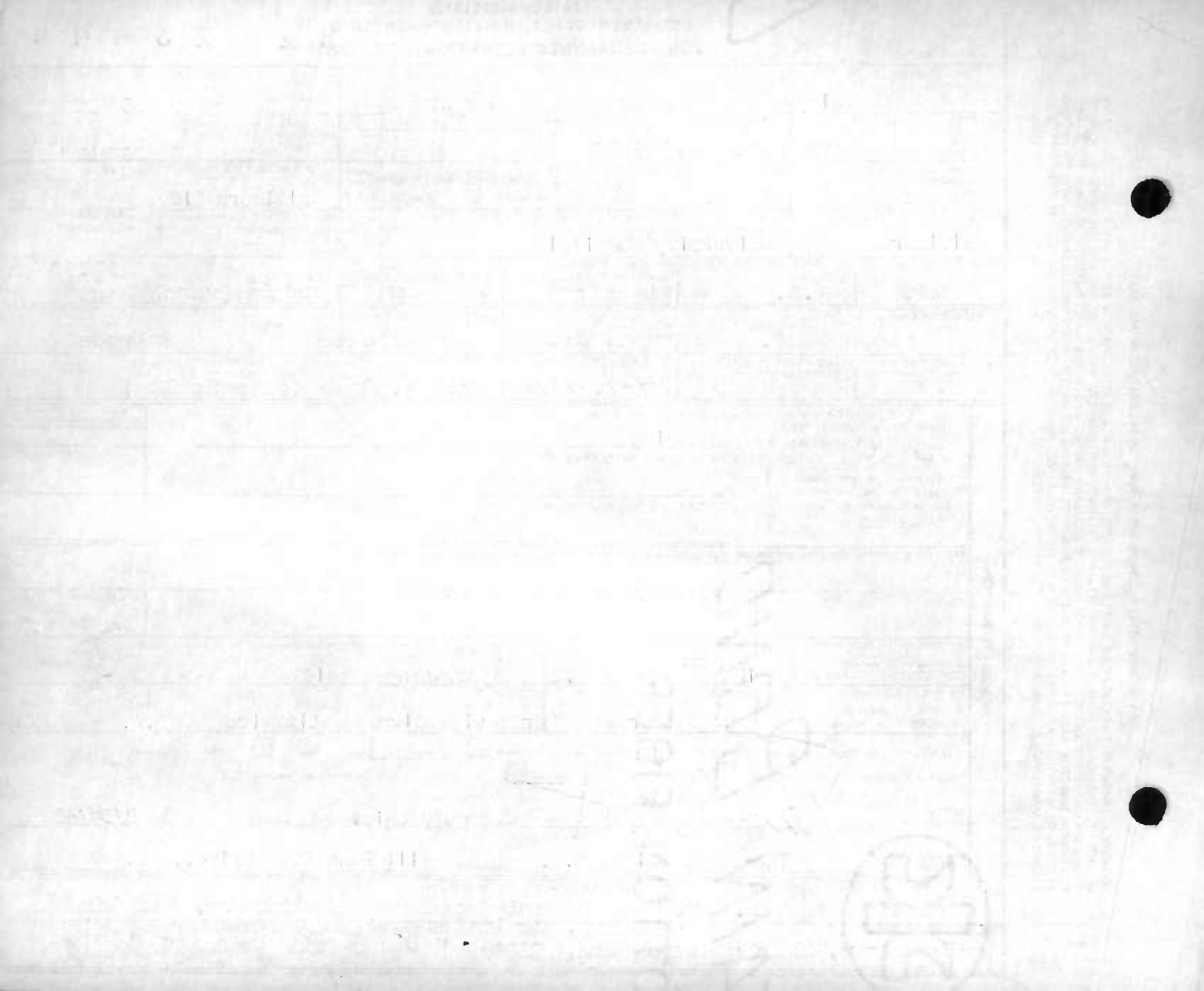
42 1021-11 - 11

For General Jones 4011 1st. Lincoln Ave.  
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                          |                                                                                   |                                                                                                                                                          |                                                                                                             |                                                                                              |                                                                                                                     |                                                                                     |                                              | REG. NO. 2 2 3 4 4 4 |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------------------------------|----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Floyd Felix Savant 3rd</b>                                                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                          |                                                                                   |                                                                                                                                                          |                                                                                                             | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>9 30 19 82</b> |                                                                                                                     | 2b. HOUR <b>2 A</b>                                                                 |                                              |                      |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                         | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Mar. 17, '65</b>                                                                                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>17</b> YRS.                                 | IF UNDER 1 YR.<br>MONTHS DAYS                                                                                                                            | IF UNDER 24 HRS.<br>HOURS MIN.                                                                              | 7c. DATE PRONOUNCED DEAD<br><b>9 30 19 82</b>                                                |                                                                                                                     | 2d. HOUR <b>2 A</b>                                                                 |                                              |                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Texas</b>                                                                                                                                                                                                                                                                                                                                                                                                     |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>                                                                                             |                                                                                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                             | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>Baltimore City,</b> MD.                    |                                                                                                                     |                                                                                     |                                              |                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |                                                                                   |                                                                                                                                                          |                                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>student</b>              |                                                                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY                                                   |                                              |                      |  |
| 13a. STATE <b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                          |                                                                                   |                                                                                                                                                          |                                                                                                             | 13b. COUNTY <b>A.A.</b>                                                                      |                                                                                                                     | 13c. CITY OR TOWN <b>Linthicum</b>                                                  |                                              |                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Floyd F. Savant, Jr.</b>                                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                          |                                                                                   |                                                                                                                                                          |                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Charlotte Salwson</b>                    |                                                                                                                     |                                                                                     |                                              |                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                          | 16b. SOCIAL SECURITY NO.<br><b>219-92-1318</b>                                    |                                                                                                                                                          | 17. INFORMANT ADDRESS<br><b>David M. Rowe (same as 13e)</b>                                                 |                                                                                              |                                                                                                                     |                                                                                     |                                              |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9530 IMMEDIATE CAUSE (a) Hanging</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                                                            |                         |                                                                                                                                          |                                                                                   |                                                                                                                                                          |                                                                                                             |                                                                                              |                                                                                                                     |                                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                          |                                                                                   |                                                                                                                                                          |                                                                                                             |                                                                                              |                                                                                                                     |                                                                                     |                                              |                      |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                 |                                                                                                                                                          |                                                                                                             |                                                                                              |                                                                                                                     | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                              |                      |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                          | 21b. TIME OF INJURY<br>HOUR <b>11:40</b> P.M. MONTH DAY YEAR <b>9 24 19 82</b>    |                                                                                                                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Subject hanged self</b> |                                                                                              |                                                                                                                     |                                                                                     |                                              |                      |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                          | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>wooded area</b> |                                                                                                                                                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Broadview Blvd. Linthicum A.A. Md.</b>              |                                                                                              |                                                                                                                     |                                                                                     |                                              |                      |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural Causes</b> <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |                                                                                                                                          |                                                                                   |                                                                                                                                                          |                                                                                                             |                                                                                              |                                                                                                                     |                                                                                     |                                              |                      |  |
| ACTUAL SIGNATURE<br>                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                          | TITLE (SPECIFY)<br><b>M.D. Deputy Chief</b>                                       |                                                                                                                                                          |                                                                                                             |                                                                                              |                                                                                                                     | DATE SIGNED <b>9/30/82</b>                                                          |                                              |                      |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Thomas D. Smith, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                          | ADDRESS <b>111 Penn St. Balto., MD.</b>                                           |                                                                                                                                                          |                                                                                                             |                                                                                              |                                                                                                                     |                                                                                     |                                              |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                          | 23b. DATE<br><b>Oct. 2, '82</b>                                                   |                                                                                                                                                          | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount Cemetery</b>                                            |                                                                                              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                                            |                                                                                     |                                              |                      |  |
| 24a. NAME<br><b>Charlotte Rowe</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                          | 24b. ADDRESS<br><b>713 Cabin Branch Lane, 21090</b>                               |                                                                                                                                                          | 24c. DATE REC'D. BY REGISTRAR<br><b>OCT 6 1982</b>                                                          |                                                                                              | 24d. REGISTRAR'S SIGNATURE<br> |                                                                                     |                                              |                      |  |

BP \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80  
(VRA 15, 4)1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 2 3 4 4 5  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                |                                                       |                                                                                                                                                             |                                                                       |                                                                                      |                                        |                                                                                                                            |                                                                                                 |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Baby Boy SAXON</b>                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 12 82</b> |                                                                                                                                                             |                                                                       | 2b. HOUR<br><b>6:35 AM</b>                                                           |                                        |                                                                                                                            |                                                                                                 |  |
| 3. SEX<br><b>Boy</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>white</b>                                                                                                                        |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 12 82</b>                                                                                                        |                                                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>✓</b>                                          |                                        | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>5 20</b>                                                                              |                                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                     |                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |                                        |                                                                                                                            |                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore Gen. Hosp.</b> |                                                       |                                                                                                                                                             |                                                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>fetus</b>     |                                        | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>N/A</b>                                                                            |                                                                                                 |  |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                |                                                       |                                                                                                                                                             | 13b. COUNTY<br><b>Anne Arundel</b>                                    |                                                                                      | 13c. CITY OR TOWN<br><b>Gen Burnie</b> |                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Daniel S. Saxon</b>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                |                                                       |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Jean M. Hardy</b> |                                                                                      |                                        |                                                                                                                            |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.<br><b>NONE</b>                                                                                                        |                                                       | 17. INFORMANT ADDRESS<br><b>Jean Saxon 927 Point Pleasant Rd.</b>                                                                                           |                                                                       |                                                                                      |                                        |                                                                                                                            |                                                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>prematurity (22 wk gestation)</b><br>7621<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Spontaneous abortion</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                                |                                                       |                                                                                                                                                             |                                                                       |                                                                                      |                                        |                                                                                                                            |                                                                                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                |                                                       |                                                                                                                                                             |                                                                       |                                                                                      |                                        |                                                                                                                            |                                                                                                 |  |
| 19a. DATE OF OPERATION<br><b>NONE</b>                                                                                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                               |                                                       |                                                                                                                                                             |                                                                       | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                            |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                              |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                                       |                                                                                      |                                        |                                                                                                                            |                                                                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                         |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                       |                                                                                      |                                        |                                                                                                                            |                                                                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 12, 1982</b> , to <b>Sept. 12, 1982</b> , that (I) (we) lost saw the deceased alive on <b>Sept 12, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                   |  |                                                                                                                                                |                                                       |                                                                                                                                                             |                                                                       |                                                                                      |                                        |                                                                                                                            |                                                                                                 |  |
| 22b. SIGNATURE<br><b>G K Gellately MD</b>                                                                                                                                                                                                                                                                                                                                                                                                           |  | DEGREE                                                                                                                                         |                                                       | 22c. DATE SIGNED<br><b>9/12/82</b>                                                                                                                          |                                                                       |                                                                                      |                                        |                                                                                                                            |                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>G K Gellately</b>                                                                                                                                                                                                                                                                                                                                                                                       |  | 22e. ADDRESS<br><b>South Baltimore Gen Hosp.</b>                                                                                               |                                                       | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |                                                                       |                                                                                      |                                        |                                                                                                                            |                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br><b>9/16/82</b>                                                                                                                    |                                                       | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |                                                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                           |                                        |                                                                                                                            |                                                                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                |                                                       | ADDRESS<br><b>Balto., Md.</b>                                                                                                                               |                                                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 20 1982</b>                                  |                                        | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Cairns</b>                                                                        |                                                                                                 |  |



20% COTTON - RIFLE

100% COTTON - RIFLE

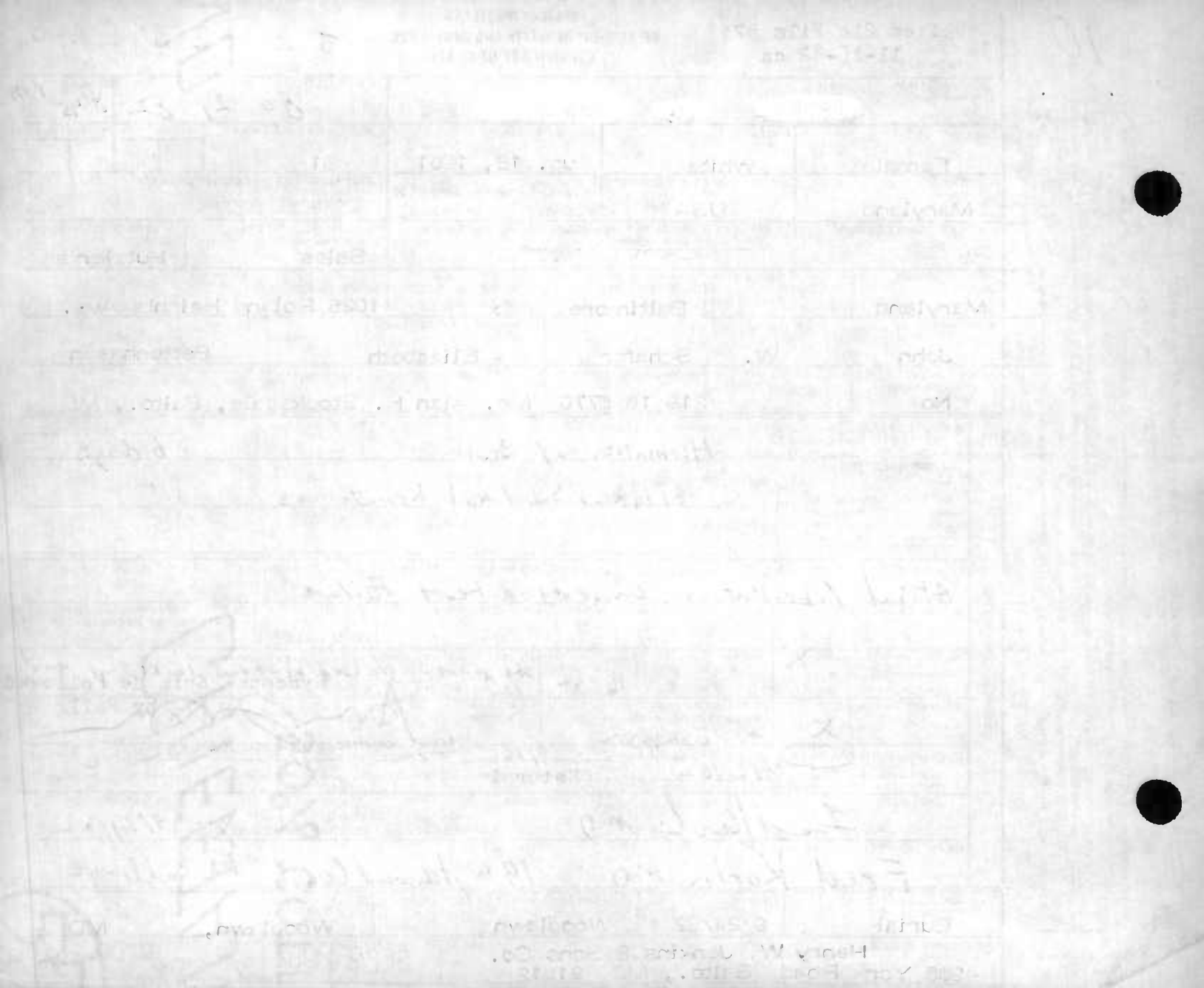


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                      |  |                                                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 10<br>FOR Item 21c Film 573<br>1- STATE REGISTRAR 11-16-82 cn                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                      |  |                                                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ESTHER B. SCHAFER                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                      |  |                                                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>09 21 82                                      |  | 2b. HOUR<br>8:45 PM                                                                                                        |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br>White                                                                                                                     |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug. 18, 1901                                                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.                                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                 |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  |                                                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sales            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Hutzler's                                                                             |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY<br>Baltimore                                                                                                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                             |  | 13e. STREET ADDRESS<br>1025 Roland Heights Ave.                                      |  |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John W. Schafer                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Bettenhasen                                                                                                                      |  |                                                                                      |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219 16 6770                                                               |  | 17. INFORMANT<br>ADDRESS<br>Mr. Alan H. Stocksdales, Balto., MD                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Herniation of Brain</u><br><u>4321</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>Bilateral Subdural Hematomas</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                      |  |                                                                                                                                                                                             |  |                                                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>6 days</u>                                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.<br><u>Atrial Fibrillation, Congestive heart failure</u>                                                                                                                                                                                                               |  |                                                                                                                                      |  |                                                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                     |  |                                                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 9 16 82                                                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><u>she suddenly grabbed her head, looked up and fell to the ground</u><br><u>Syncope Episode Followed</u> |  |                                                                                      |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><u>While shopping</u>                                      |  | 21f. LOCATION<br>STREET CITY STATE<br><u>Fall</u>                                                                                                                                           |  |                                                                                      |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/16</u> to <u>9/21</u> , that (I) (we) last saw the deceased alive on <u>09/21/82</u> , 19 <u>Natural</u> (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.                                                                                   |  |                                                                                                                                      |  |                                                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>Fred Karlin M.D.</u>                                                                                                                                                                                                                                                                                                                                                                 |  | DEGREE                                                                                                                               |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                                                  |  |                                                                                      |  | 22c. DATE SIGNED<br><u>9/21/82</u>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Fred Karlin M.D.</u>                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                      |  | 22e. ADDRESS<br><u>19 Wythwood Court # Fx Baltimore</u>                                                                                                                                     |  |                                                                                      |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                       |  | 23b. DATE<br>9/24/82                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn                                                                                                                                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Woodlawn MD                            |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                      |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 24 1982                                                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Connel</u>                                  |  |                                                                                                                            |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified by the funeral director.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                            |                                                                                                                                                                        |  | REG. NO. 8 2 2 3 4 4 7                                                                                                                                    |  |                                                                                                                            |                                              |          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|----------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                            |                                                                                                                                                                        |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                                          |  |                                                                                                                            |                                              | 2b. HOUR |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>GLADYS M SCHAFER                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                            |                                                                                                                                                                        |  | 09/20/82                                                                                                                                                  |  |                                                                                                                            |                                              | 2:17 PM  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                      | 4. RACE<br>White                                                                                                                           | 5. DATE OF BIRTH MONTH DAY YEAR<br>9 21 01                                                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS                                                                                                                 |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.                                                               |                                              |          |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                 | 8b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                                                                                |  |                                                                                                                            |                                              |          |
| 10. CITY OR TOWN OF DEATH<br>BALTO., CITY                                                                                                                                                                                                                                                                                                                                                                                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes hospital, Baltimore |                                                                                                                                                                        |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                                                                             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>---                                                                                   |                                              |          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore                                                                                                                                                                                                                                                                 |                                                                                                                                            |                                                                                                                                                                        |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                              |  |                                                                                                                            |                                              |          |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Edward Ehrhart                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                            |                                                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Phoebe Ringold                                                                                              |  |                                                                                                                            |                                              |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                            | 16b. SOCIAL SECURITY NO.<br>214-74-7416                                                                                                                                |  | 17. INFORMANT ADDRESS 21229<br>John R. Schafer 3rd. 1110 Pine Heights Ave.                                                                                |  |                                                                                                                            |                                              |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac Asystole<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Extensive Acute Myocardial Infarction<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) ASCVD<br>DUE TO, OR AS A CONSEQUENCE OF<br>With VSD with CHF with Acute Renal Failure |                                                                                                                                            |                                                                                                                                                                        |  |                                                                                                                                                           |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                                                                                    |                                                                                                                                            |                                                                                                                                                                        |  |                                                                                                                                                           |  |                                                                                                                            |                                              |          |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                 |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                              |                                                                                                                                            | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)                                                                           |  |                                                                                                                            |                                              |          |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                             |                                                                                                                                            | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                         |  |                                                                                                                            |                                              |          |
| 22a. I certify that (1) this hospital attended the deceased from 9-16 19 82, to 9-20 19 82, that (1) (we) lost saw the deceased alive on 9-20 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (us) did not view the body after death.                                                                                                                             |                                                                                                                                            |                                                                                                                                                                        |  |                                                                                                                                                           |  |                                                                                                                            |                                              |          |
| 22b. SIGNATURE<br>P. V. Karam                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                            |                                                                                                                                                                        |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>9-20-82                                                                                                |                                              |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KANANI                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                            |                                                                                                                                                                        |  | 22e. ADDRESS<br>St. Agnes hospital, Baltimore, Md.                                                                                                        |  |                                                                                                                            |                                              |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                            | 23b. DATE<br>9/23/82                                                                                                                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery                                                                                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                                           |                                              |          |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc.                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                            |                                                                                                                                                                        |  | 21229<br>ADDRESS<br>4107 Wilkens Ave.                                                                                                                     |  | 25a. DATED BY REGISTRAR<br>SEP 22 1982                                                                                     |                                              |          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                            |                                                                                                                                                                        |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Carver                                                                                                              |  |                                                                                                                            |                                              |          |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and temporarily filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                       |  |                                                                                                                              |  |                                                                                                                                                          |  |                                                                                   |  |                                                                                                                         |  |                                                      |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                     |  | REG. NO. 8 2 2 3 4 4 8                                                                                                       |  |                                                                                                                                                          |  |                                                                                   |  |                                                                                                                         |  |                                                      |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                           |  | FIRST ELISE                                                                                                                  |  | MIDDLE W.                                                                                                                                                |  | LAST WILHELMINA SCHLAILE                                                          |  | 2a. DATE OF DEATH MONTH DAY YEAR 09-29-82                                                                               |  | 2b. HOUR 6:40pm <sup>M</sup>                         |  |
| 3. SEX FEMALE                                                                                                                                                                                                                                                                              |  | 4. RACE WHITE                                                                                                                |  | 5. DATE OF BIRTH MONTH DAY YEAR 9/7/1894                                                                                                                 |  | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.                                           |  | IF UNDER 1 YEAR MONTHS DAYS                                                                                             |  | IF UNDER 24 HRS. HOURS MIN.                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GERMANY                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.                                                                                          |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD                            |  |                                                                                                                         |  |                                                      |  |
| 10. CITY OR TOWN OF DEATH BALTIMORE                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOSPITAL, INC. |  |                                                                                                                                                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER           |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |  |                                                      |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTO.                                                                                                                                                        |  |                                                                                                                              |  |                                                                                                                                                          |  | 13c. CITY OR TOWN DUNDALK                                                         |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 13e. STREET ADDRESS 2110 DUNDALK AVE. 21222          |  |
| 14. FATHER'S NAME FIRST UNKNOWN MIDDLE LAST LOHMANN                                                                                                                                                                                                                                        |  |                                                                                                                              |  | 15. MOTHER'S MAIDEN NAME FIRST UNKNOWN MIDDLE LAST UNKNOWN                                                                                               |  |                                                                                   |  |                                                                                                                         |  |                                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO                                                                                                                                                                                                                       |  | 16b. SOCIAL SECURITY NO. 212.48.4368                                                                                         |  | 17. INFORMANT ADDRESS CARL L. SCHLAILE (SON) SAME AS 13e                                                                                                 |  |                                                                                   |  |                                                                                                                         |  |                                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. 4275 IMMEDIATE CAUSE (a) CARDIAC STANDSTILL                                                                                                                                          |  |                                                                                                                              |  |                                                                                                                                                          |  |                                                                                   |  |                                                                                                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                       |  |                                                                                                                              |  |                                                                                                                                                          |  |                                                                                   |  |                                                                                                                         |  |                                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                        |  |                                                                                                                              |  |                                                                                                                                                          |  |                                                                                   |  |                                                                                                                         |  |                                                      |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                             |  |                                                                                                                                                          |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                                                                           |  |                                                                                   |  |                                                                                                                         |  |                                                      |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                          |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                   |  |                                                                                                                         |  |                                                      |  |
| 22a. I certify that (1) this hospital attended the deceased from 09-29-19-82, to 09-29-19-82, that (1) I saw the deceased alive on 09-29-19-82, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (If not, did not see the body after death.) |  |                                                                                                                              |  |                                                                                                                                                          |  |                                                                                   |  |                                                                                                                         |  |                                                      |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                             |  | DEGREE                                                                                                                       |  | 22c. DATE SIGNED                                                                                                                                         |  |                                                                                   |  |                                                                                                                         |  |                                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. PAUL GORMLEY M.D.                                                                                                                                                                                                                                |  | 22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MARYLAND 21231                                           |  | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>          |  |                                                                                   |  |                                                                                                                         |  |                                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial                                                                                                                                                                                                                                           |  | 23b. DATE 10/2/1982                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEMETERY                                                                                                     |  | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND                        |  |                                                                                                                         |  |                                                      |  |
| 24. FUNERAL DIRECTOR WALTER BROOKS BRADLEY, INC., DUNDALK, MD. 21222                                                                                                                                                                                                                       |  |                                                                                                                              |  |                                                                                                                                                          |  | 25. DATE REC'D. BY REGISTRAR OCT 5 1982                                           |  | 25. REGISTRAR'S SIGNATURE John J. Connel                                                                                |  |                                                      |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please see page 1 of this certificate for instructions. The law requires that the death certificate be executed within 24 hours after death. Please see page 1 of this certificate for instructions.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner will be notified and a necropsy will be required.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 4 4 9

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                  |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Raymond E. Schneehagen</b>                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                  |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9-5-82 09 05 82</b>                                   |                                                                                      | 2b. HOUR<br><b>346AM</b>                                                                                                   |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                              | 4. RACE<br><b>Caucasian</b>                                                                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10-16-1917</b>                                                                                                     |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64 yrs.</b>                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |
| 7. BIRTHPLACE (STATE OR FOREIGN)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                        |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(GIVE FULL NAME AND STREET ADDRESS)<br><b>Union Memorial Hospital</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(GIVE WORK OR MAIN SOURCE OF WORKING LIFE)<br><b>Salesman</b>          | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Exxon</b>                                    |                                                                                                                            |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>BALTO.</b> 13c. CITY OR TOWN <b>BALTO.</b>                                                                                                                                                                                                                     |                                                                                                                                  |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>3122 Mareco Avenue 21213</b>                               |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Schneehagen</b>                                                                                                                                                                                                                                                                                                                               |                                                                                                                                  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Dora Lungar</b>                             |                                                                                      |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN) <b>no</b>                                                                                                                                                                                                                                                                                                                         |                                                                                                                                  | 16b. SOCIAL SECURITY NO.<br><b>217-09-7513</b>                                                                                                              | 17. INFORMANT<br>ADDRESS<br><b>Naomi Schneehagen 3122 Mareco Avenue 21213</b>                   |                                                                                      |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4100 Myocardial Infarction</b><br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                                                                                                                                  |                                                                                                                                                             |                                                                                                 |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr</b>                                                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                                               |                                                                                                                                  |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                           |                                                                                                                                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)               |                                                                                      |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                     |                                                                                                                                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                      |                                                                                                                            |
| 22a. I certify that (this hospital) attended the deceased from <b>9/1/82</b> to <b>9/5/82</b> that (we) lost<br>saw the deceased alive on <b>9/1/82</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If (we) did not view the body after death, so state.)                                                                                |                                                                                                                                  |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                            |
| 22b. SIGNATURE<br><b>Ira H. Copeland MD</b>                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                  |                                                                                                                                                             | DEGREE<br><b>MD</b>                                                                             |                                                                                      | 22c. DATE SIGNED<br><b>9/5/82</b>                                                                                          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Ira H. Copeland MD</b>                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                  |                                                                                                                                                             | 22e. ADDRESS                                                                                    |                                                                                      |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                      | 23b. DATE<br><b>9-8-82</b>                                                                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cem.</b>                                                                                          |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>                     |                                                                                                                            |
| 24. FUNERAL DIRECTOR'S NAME<br><b>Schimunek Funeral Home, Inc.</b><br><b>3331 Brehms Lane 21213</b>                                                                                                                                                                                                                                                                                                |                                                                                                                                  |                                                                                                                                                             | 25. DATE REC'D. BY REGISTRAR<br><b>SEP 7 1982</b>                                               | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Lohr</b>                                    |                                                                                                                            |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 7 2 2 3 4 5 0                                                                                                                      |  | REG. NO.                                                                                                                                                    |  |                                                                                      |  |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Herbert L. Schnitzler</i>                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                    |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <i>9-2-82</i>                                                                                                           |  | 2b. HOUR <i>4:25 AM</i>                                                              |  |                                                                                                                            |  |
| 3. SEX<br><i>Male</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br><i>White</i>                                                                                                            |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <i>02 06 06</i>                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>76</i> YRS.                                    |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>New York</i>                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                                                         |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                    |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Mercy Hospital</i> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>CLERK</i>     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>MEN'S CLOTHING</i>                                                                 |  |
| 13a. STATE<br><i>MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                    |  | 13b. COUNTY                                                                                                                                                 |  | 13c. CITY OR TOWN<br><i>BALTIMORE</i>                                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>LOUIS Schnitzler</i>                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>BELLA FULD</i>                                                                                          |  |                                                                                      |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.<br><i>220 14 8605</i>                                                                                                              |  | 17. INFORMANT<br><i>MRS. MILDRED P. SCHNITZLER</i>                                   |  |                                                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                    |  |                                                                                                                                                             |  | 600 LIGHT ST., APT. 420 BALTO., MD 21230                                             |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><i>4860</i> IMMEDIATE CAUSE (a) <i>cardio-pulmonary arrest 1/2 MI</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>acute tubular necrosis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>pneumonia</i>                                                                                                                                                          |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>MI 8/29</i>                                                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>0</i>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                      |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                             |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                      |  |                                                                                                                            |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>9/2</i> 19 <i>82</i> , to <i>9/2</i> 19 <i>82</i> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <i>9/2</i> 19 <i>82</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> did not view the body after death. |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><i>Marie A. Amos</i>                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                    |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |                                                                                      |  | 22c. DATE SIGNED<br><i>9/2/82</i>                                                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Marie A. Amos</i>                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                    |  | 22e. ADDRESS<br><i>321 Mercy Hospital Balto, Md. 21202</i>                                                                                                  |  |                                                                                      |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>BURIAL</i>                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 23b. DATE<br><i>SEPT. 3, 1982</i>                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>HEBREW FRIENDSHIP</i>                                                                                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>BALTIMORE MARYLAND</i>              |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br><i>SOL LEVINSON &amp; BROS., INC.</i><br>6010 REISTERSTOWN RD. BALTO., MD 21215                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                    |  | 25a. DATE REC'D. BY REGISTRAR<br><i>SEP 8 1982</i>                                                                                                          |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Carver</i>                                  |  |                                                                                                                            |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in case.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                           |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                               |  |                                                                           |  | 8 2 2 3 4 5 1<br>REG. NO.                                                                                                  |  |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|---------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>DOLORES A. SCHULTZ                                                                                                                                                                                                                                                                      |  |                                                                                                                                        |  |                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>09 14 82                               |  |                                                                           |  | 2b. HOUR<br>P. M.                                                                                                          |  |  |  |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br>White                                                                                                                       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>05 05 10                                                                                                              |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                            |  | IF UNDER 24 HRS.<br>HOURS MIN.                                                                                             |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                 |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                    |  |                                                                           |  |                                                                                                                            |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>5154 Stafford Road, 21229 |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>---                                  |  |                                                                                                                            |  |  |  |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                        |  |                                                                                                                                                             |  | 13b. COUNTY<br>---                                                            |  | 13c. CITY OR TOWN<br>BALTIMORE                                            |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>CONRAD KAPRAUN                                                                                                                                                                                                                                                                       |  |                                                                                                                                        |  |                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>CHRISTINE HOHMAN             |  |                                                                           |  |                                                                                                                            |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                                                                                                                                                                                                                         |  |                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br>213-05-2514                                                                                                                     |  | 17. INFORMANT<br>TERRY SCHULTZ 5154 STAFFORD ROAD, 21229                      |  |                                                                           |  |                                                                                                                            |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>1579 IMMEDIATE CAUSE (a) Metastatic Carcinoma - Pancreas etc.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Carcinoma Pancreas<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                               |  |                                                                           |  |                                                                                                                            |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                            |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                               |  |                                                                           |  |                                                                                                                            |  |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                                               |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                       |  |                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                                                           |  |                                                                                                                            |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                   |  |                                                                                                                                        |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |                                                                           |  |                                                                                                                            |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/26/82 to present, 19, that (I) (we) last saw the deceased alive on 7/26/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                      |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                               |  |                                                                           |  |                                                                                                                            |  |  |  |  |
| 22b. SIGNATURE<br>Elie K. Fraiji                                                                                                                                                                                                                                                                                               |  |                                                                                                                                        |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |                                                                               |  | 22c. DATE SIGNED<br>9/18/82                                               |  |                                                                                                                            |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Elie K. Fraiji                                                                                                                                                                                                                                                                        |  |                                                                                                                                        |  | 22e. ADDRESS<br>St. Agnes Medical Center                                                                                                                    |  |                                                                               |  |                                                                           |  |                                                                                                                            |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                         |  |                                                                                                                                        |  | 23b. DATE<br>09-18-82                                                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br>NEW CATHEDRAL                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE CITY MARYLAND     |  |                                                                                                                            |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.                                                                                                                                                                                                                                                   |  |                                                                                                                                        |  | ADDRESS<br>21229                                                                                                                                            |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 16 1982                                  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Smith                               |  |                                                                                                                            |  |  |  |  |

TO THE HONORABLE JUDGE OF THE COURT  
THE undersigned, JAMES H. HARRIS, of the County of New York, State of New York, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the Court.

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the Court at New York, New York, this 1st day of January, 1901.

JAMES H. HARRIS, Clerk of the Court.  
By \_\_\_\_\_, Deputy Clerk of the Court.



FILED

2025-01-01

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                       |                                                      |                                                                                                                                                          |                                |                                                                                                         |  |                                                                                                  |  | REG. NO. 2 2 3 4 5 2 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|---------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------|--|----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>TIMOTHY J. SCHULTZ</b>                                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                       |                                                      |                                                                                                                                                          |                                | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 9 4 19 82                      |  | 7b. HOUR<br>M                                                                                    |  |                      |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11-29-1958</b>                                                                                               | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>23 YRS.</b> | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                                                                                                 | IF UNDER 24 HRS.<br>HOURS MIN. | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>9 7 19 82</b>                                          |  | 2d. HOUR<br>M <b>2p</b>                                                                          |  |                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                               |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                         |                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                       |  |                                                                                                  |  |                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                         |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>park-2600 blk. Chesterfield Ave.</b> |                                                      |                                                                                                                                                          |                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b>                           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto City</b>                                           |  |                      |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |                         | 13b. COUNTY<br><b>-</b>                                                                                                                               |                                                      | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                    |                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>         |  | 13e. STREET ADDRESS<br><b>3565 Lyndale Ave. 21213</b>                                            |  |                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Paul A. Schultz</b>                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                       |                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rosa L. Wong</b>                                                                                     |                                |                                                                                                         |  |                                                                                                  |  |                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>yes</b>                                                                                                                                                                                                                                                                                                                                                                   |                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>Peacetime</b>                                                                           |                                                      | 17. INFORMANT<br><b>Paul Schultz (father)</b>                                                                                                            |                                | ADDRESS<br><b>same address</b>                                                                          |  |                                                                                                  |  |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gunshot wound of head (handgun)</b><br><b>9550</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                  |                         |                                                                                                                                                       |                                                      |                                                                                                                                                          |                                |                                                                                                         |  |                                                                                                  |  |                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                       |                                                      |                                                                                                                                                          |                                |                                                                                                         |  |                                                                                                  |  |                      |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                       |                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                        |                                |                                                                                                         |  | 20. AUTOPSY?<br>HEAD ONLY<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                      |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                       |                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>? P.M. 9-4- 1982</b>                                                                               |                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>Self-inflicted.</b> |  |                                                                                                  |  |                      |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                       |                                                      | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>park</b>                                                                               |                                | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>2600 blk. Chesterfield Ave., Balto. City, Md.</b>      |  |                                                                                                  |  |                      |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . |                         |                                                                                                                                                       |                                                      |                                                                                                                                                          |                                |                                                                                                         |  |                                                                                                  |  |                      |  |
| ACTUAL SIGNATURE<br><b>Ann M. Dixon</b>                                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                       |                                                      | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER                                                                                                |                                |                                                                                                         |  | DATE SIGNED<br><b>9-8-82</b>                                                                     |  |                      |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                       |                                                      | ADDRESS<br><b>111 Penn St., Balto., Md. 21201</b>                                                                                                        |                                |                                                                                                         |  |                                                                                                  |  |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                            |                         | 23b. DATE<br><b>9/10/82</b>                                                                                                                           |                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>                                                                                               |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                                      |  |                                                                                                  |  |                      |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Schlimunek Funeral Home, Inc.<br/>3331 Brehms Lane, Balto. Md. 21213</b>                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                       |                                                      |                                                                                                                                                          |                                | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 10 1982</b>                                                     |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>                                              |  |                      |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and a medical certificate must be filed.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                       |  | 8 2 2 3 4 5 3<br>REG. NO.                                                                                                                                   |  |                                                                                                                            |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Henry B. Schweiger                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                       |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>September 16, 1982                                                                                                      |  |                                                                                                                            |                                              |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br>White                                                                                                                      |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 1, 1906                                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76                                                                                      |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                                                |                                              |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospitals |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Western Elec                                                                          |                                              |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                       |  | 13b. COUNTY<br>Baltimore                                                                                                                                    |  | 13c. CITY OR TOWN<br>Dundalk                                                                                               |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edward C. Schweiger                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                       |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emma Apple                                                                                                 |  |                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-01-9613                                                                |  | 17. INFORMANT ADDRESS<br>Lillian E. Schweiger (same as line 13)                                                                                             |  |                                                                                                                            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Coronary artery thrombosis</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>arterio-sclerotic heart disease</u><br>1968<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                              |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>cardiopulmonary insufficiency</u>                                                                                                                                                                                                                                                  |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE, FARM, ETC.)                                                                  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-30</u> 19 <u>82</u> , to <u>6-30</u> 19 <u>82</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>6-30</u> 19 <u>82</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above; (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death. |  |                                                                                                                                       |  |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 22b. SIGNATURE<br><u>Lester Lebo MD</u>                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>9/17/82                                                                                                |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Lester Lebo, MD                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                       |  | 22e. ADDRESS<br>Medical Arts Building, Balt., Md.                                                                                                           |  |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                           |  | 23b. DATE<br>Sept. 20, 82                                                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Dorsey, Maryland, Howard Co                                                                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                                                 |                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br>Duda-Ruck Funeral Home of Dundalk, Inc.                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 17 1982                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Grier</u>                                                                         |                                              |

2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                         |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                |                                                               |                                                                     |                                   |                                                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------|----------------------------------------------------------------|
| 1. FOR Item 13 Phone 9-24-82<br>STATE REGISTRAR                                                                                                                                                                                                                                                              |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                |                                                               |                                                                     |                                   |                                                                |
| DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                             |  |                                                                                                        |                                                                     |                                                                                                                                                          | 2a. DATE OF DEATH                                                              |                                                               |                                                                     |                                   |                                                                |
| BABY BOY SCOTT                                                                                                                                                                                                                                                                                               |  |                                                                                                        |                                                                     |                                                                                                                                                          | 6 22 82 12 06 PM                                                               |                                                               |                                                                     |                                   |                                                                |
| 3. SEX                                                                                                                                                                                                                                                                                                       |  | 4. RACE                                                                                                |                                                                     | 5. DATE OF BIRTH                                                                                                                                         |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)                               |                                                                     | 7. IF UNDER 1 YEAR                |                                                                |
| MALE                                                                                                                                                                                                                                                                                                         |  | BLACK                                                                                                  |                                                                     | 6 22 82                                                                                                                                                  |                                                                                | 0 YRS                                                         |                                                                     | 0 MONTHS 0 DAYS 26 HOURS 0 MIN.   |                                                                |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |                                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |                                                                     |                                   |                                                                |
| MARYLAND                                                                                                                                                                                                                                                                                                     |  | USA                                                                                                    |                                                                     |                                                                                                                                                          |                                                                                | BALTO. CITY MD.                                               |                                                                     |                                   |                                                                |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                     |                                                                                                                                                          |                                                                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY |                                                                |
| BALTO. CITY                                                                                                                                                                                                                                                                                                  |  | SINAI HOSPITAL                                                                                         |                                                                     |                                                                                                                                                          |                                                                                | NONE                                                          |                                                                     | NONE                              |                                                                |
| 13a. STATE                                                                                                                                                                                                                                                                                                   |  |                                                                                                        |                                                                     |                                                                                                                                                          | 13b. CITY OR TOWN                                                              |                                                               | 13c. STREET ADDRESS                                                 |                                   |                                                                |
| MD N/A                                                                                                                                                                                                                                                                                                       |  |                                                                                                        |                                                                     |                                                                                                                                                          | BALTIMORE                                                                      |                                                               | N 2936 Clifton Ave                                                  |                                   |                                                                |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                            |  |                                                                                                        |                                                                     |                                                                                                                                                          | 15. MOTHER'S MAIDEN NAME                                                       |                                                               |                                                                     |                                   |                                                                |
| STERLING Mccollum                                                                                                                                                                                                                                                                                            |  |                                                                                                        |                                                                     |                                                                                                                                                          | PAMELA SCOTT                                                                   |                                                               |                                                                     |                                   |                                                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                            |  |                                                                                                        |                                                                     |                                                                                                                                                          | 16b. SOCIAL SECURITY NO.                                                       |                                                               | 17. INFORMANT ADDRESS                                               |                                   |                                                                |
| NO                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |                                                                     |                                                                                                                                                          | N/A                                                                            |                                                               | Pamela Scott 2936 Clifton Ave                                       |                                   |                                                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                    |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                |                                                               |                                                                     |                                   |                                                                |
| PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                 |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                |                                                               |                                                                     |                                   |                                                                |
| IMMEDIATE CAUSE (a) 7621 PREMATURE DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                            |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                |                                                               |                                                                     |                                   |                                                                |
| (b) SPONTANEOUS MISCARRIAGE                                                                                                                                                                                                                                                                                  |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                |                                                               |                                                                     |                                   |                                                                |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                                           |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                |                                                               |                                                                     |                                   |                                                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NONE                                                                                                                                                                        |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                |                                                               |                                                                     |                                   |                                                                |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                       |  |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                                                                                                                                          |                                                                                |                                                               | 20a. AUTOPSY?                                                       |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| N/A                                                                                                                                                                                                                                                                                                          |  |                                                                                                        | N/A                                                                 |                                                                                                                                                          |                                                                                |                                                               | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                           |  |                                                                                                        | 21b. TIME OF INJURY                                                 |                                                                                                                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                               |                                                                     |                                   |                                                                |
|                                                                                                                                                                                                                                                                                                              |  |                                                                                                        | HOUR A.M. MONTH DAY YEAR                                            |                                                                                                                                                          |                                                                                |                                                               |                                                                     |                                   |                                                                |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                         |  |                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                          | 21f. LOCATION                                                                  |                                                               |                                                                     |                                   |                                                                |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                            |  |                                                                                                        |                                                                     |                                                                                                                                                          | CITY OR TOWN COUNTY STATE                                                      |                                                               |                                                                     |                                   |                                                                |
| 22. I certify that (I) (this hospital) attended the deceased from 6/22 19 82 to 6/22 19 82, that (I) (we) lost saw the deceased alive on 6/22 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                        |                                                                     |                                                                                                                                                          |                                                                                |                                                               |                                                                     |                                   |                                                                |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                               |  |                                                                                                        |                                                                     |                                                                                                                                                          | DEGREE                                                                         |                                                               |                                                                     | 22c. DATE SIGNED                  |                                                                |
| Mosh Cooper                                                                                                                                                                                                                                                                                                  |  |                                                                                                        |                                                                     |                                                                                                                                                          | MD                                                                             |                                                               |                                                                     | 6/22/82                           |                                                                |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                        |  |                                                                                                        |                                                                     |                                                                                                                                                          | 22e. ADDRESS                                                                   |                                                               |                                                                     |                                   |                                                                |
| MOSHAY COOPER MD                                                                                                                                                                                                                                                                                             |  |                                                                                                        |                                                                     |                                                                                                                                                          | Belvedere at Greenspring Ave 21215                                             |                                                               |                                                                     |                                   |                                                                |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                    |  |                                                                                                        | 23b. DATE                                                           |                                                                                                                                                          | 23c. NAME OF CEMETERY OR CREMATORY                                             |                                                               | 23d. LOCATION                                                       |                                   |                                                                |
| CREATION                                                                                                                                                                                                                                                                                                     |  |                                                                                                        | 6-28-82                                                             |                                                                                                                                                          | Sinai Hospital                                                                 |                                                               | BALTIMORE, MD                                                       |                                   |                                                                |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                    |  |                                                                                                        |                                                                     |                                                                                                                                                          | 25. DATE REC'D. BY REGISTRAR                                                   |                                                               |                                                                     |                                   |                                                                |
|                                                                                                                                                                                                                                                                                                              |  |                                                                                                        |                                                                     |                                                                                                                                                          | SEP 23 1982                                                                    |                                                               |                                                                     |                                   |                                                                |

STOILS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 2 2 3 4 5 5

|                                                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                  |                                                                                   |                                                                                                                                                             |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ANNA Margaret SCOTT</b>                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 25 82</b>                             |                                                                                                                                                             | 2b. HOUR<br><b>8<sup>20</sup> A.M.</b>       |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 14 26</b>                                             |                                                                                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS.                                                                                                           |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Balto., Md.</b>                                                                                                                                                                                                                                                                                                                                                                |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                    |                                                                                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                              |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                                                                                                                                                                                                                                                                                                                      |                         | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                    |                                                                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospitals</b>                |                                              |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housework</b>                                                                                                                                                                                                                                                                                                                                   |                         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>                                              |                                                                                   | 13a. STREET ADDRESS<br><b>3602 Frankford Ave. 21214</b>                                                                                                     |                                              |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                          |                         | 13b. COUNTY<br><b>Baltimore</b>                                                                  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Frederick Heidel</b>                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Margaret Eggendorfer</b> |                                                                                                                                                             |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                      |                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-20-0789</b>                    |                                                                                   | 17. INFORMANT<br>ADDRESS<br><b>Marie C. Scott 3602 Frankford Ave. 21214</b>                                                                                 |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>METASTATIC ADENOCARCINOMA OF THE COLON</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                         |                                                                                                  |                                                                                   |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                                                                                                 |                         |                                                                                                  |                                                                                   |                                                                                                                                                             |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                 |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                 |                                                                                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                               |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                       |                                                                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                           |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                           |                                                                                   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                              |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>9/25/82</b> , 19 <b>82</b> , to <b>9/25</b> , 19 <b>82</b> , that (1) (we) lost saw the deceased alive on <b>9/25</b> , 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)                                                   |                         |                                                                                                  |                                                                                   |                                                                                                                                                             |                                              |
| 22b. SIGNATURE<br><b>Robert A. Weisgrau</b>                                                                                                                                                                                                                                                                                                                                                                            |                         | DEGREE<br><b>MD</b>                                                                              |                                                                                   | 22c. DATE SIGNED<br><b>9/25/82</b>                                                                                                                          |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT A. WEISGRAU MD</b>                                                                                                                                                                                                                                                                                                                                                  |                         | 22e. ADDRESS<br><b>BALTIMORE City Hospital</b>                                                   |                                                                                   |                                                                                                                                                             |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                          |                         | 23b. DATE<br><b>9-28-82</b>                                                                      |                                                                                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart Cem.</b>                                                                                              |                                              |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Dundalk Balto. Co. Md.</b>                                                                                                                                                                                                                                                                                                                                            |                         | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>C.S. Zeiler &amp; Son Inc. 901 S. Conkling Street</b> |                                                                                   |                                                                                                                                                             |                                              |
| 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 27 1982</b>                                                                                                                                                                                                                                                                                                                                                                    |                         | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connelley</b>                                           |                                                                                   |                                                                                                                                                             |                                              |

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11 12 13 14 15 16 17 18 19 20

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|--------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| Female | 1   | 2   | 3   | 4   | 5   | 6   | 7   | 8   | 9   | 10  | 11  | 12  | 13  | 14  | 15  | 16  | 17  | 18  | 19  | 20  |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 4 per phone 9/29/82 dad

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8

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3

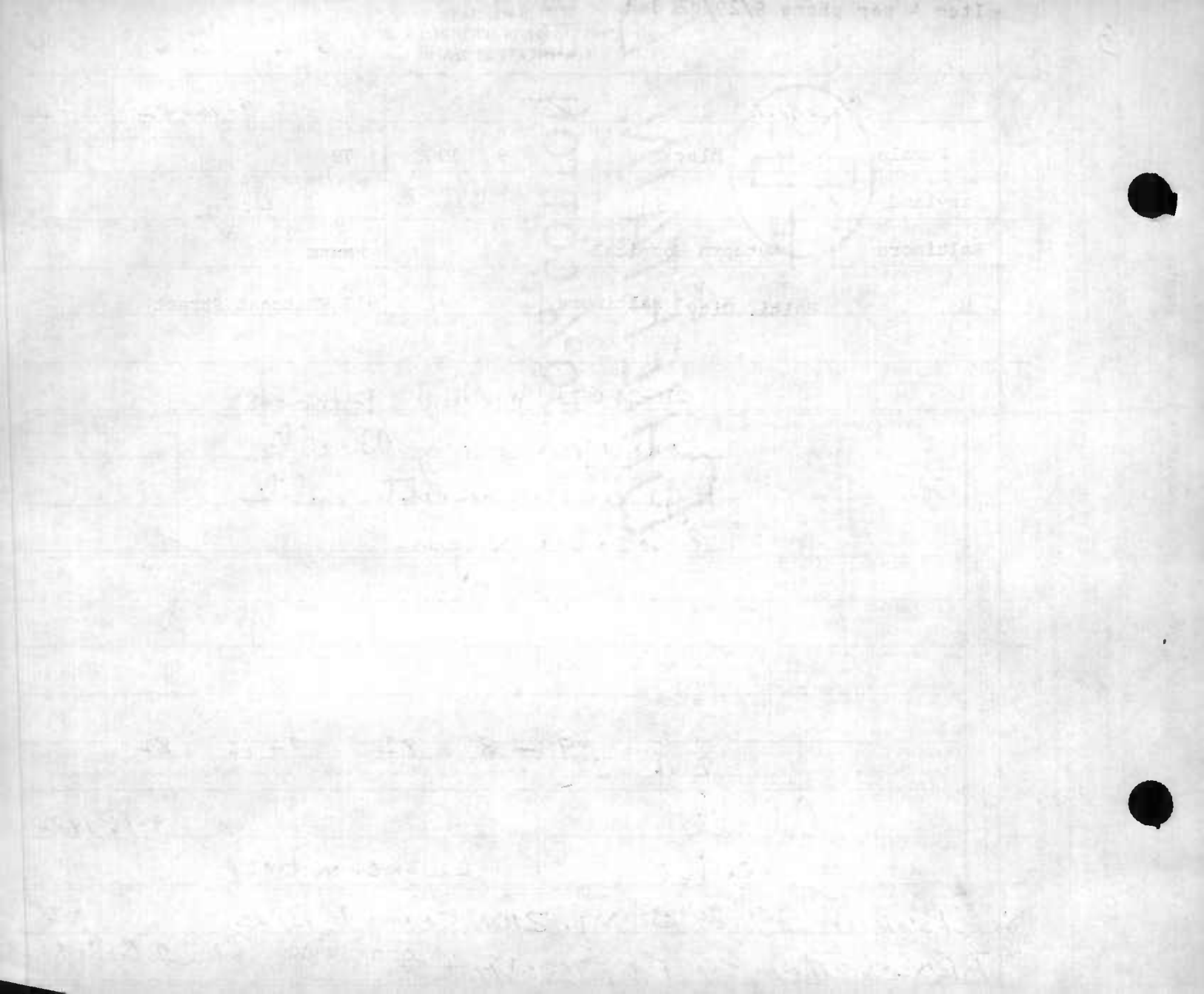
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REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                       |  |                                                                                                                                                          |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                            |  | 2a. DATE OF DEATH                                                                                     |  | 2b. HOUR                                                                                                                                                 |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                  |  | MONTH DAY YEAR                                                                                        |  | 2b. HOUR                                                                                                                                                 |  |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                 |  | 9-16-82                                                                                               |  | 2-10 AM                                                                                                                                                  |  |
| 2. SEX                                                                                                                                                                                                                                                                                                                                                            |  | 3. RACE                                                                                               |  | 4. DATE OF BIRTH                                                                                                                                         |  |
| Female                                                                                                                                                                                                                                                                                                                                                            |  | Black                                                                                                 |  | MONTH DAY YEAR                                                                                                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                       |  | 1 MONTH 9 DAY 1903                                                                                                                                       |  |
| 5. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                          |  | 6. CITIZEN OF WHAT COUNTRY?                                                                           |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                          |  | USA                                                                                                   |  |                                                                                                                                                          |  |
| 8. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                          |  | 9. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 10. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                                    |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                         |  | Luthern Hospital                                                                                      |  | C: Ty MD.                                                                                                                                                |  |
| 11. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                       |  | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                          |  | 13. KIND OF BUSINESS OR INDUSTRY                                                                                                                         |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                        |  | 13b. COUNTY                                                                                           |  | 13c. CITY OR TOWN                                                                                                                                        |  |
| Md.                                                                                                                                                                                                                                                                                                                                                               |  | Balti. City                                                                                           |  | Baltimore                                                                                                                                                |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                 |  | 15. MOTHER'S MAIDEN NAME                                                                              |  | 16. STREET ADDRESS                                                                                                                                       |  |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                 |  | FIRST MIDDLE LAST                                                                                     |  | 913 Whatcoat Street                                                                                                                                      |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                 |  | 17b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)                                                  |  | 17. INFORMANT ADDRESS                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                   |  | 216-24-0633                                                                                           |  | Medical Records                                                                                                                                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                             |  |                                                                                                       |  |                                                                                                                                                          |  |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                       |  |                                                                                                                                                          |  |
| 2502 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension nonketotic diabetes</u>                                                                                                                                                                                                                                                                                   |  |                                                                                                       |  |                                                                                                                                                          |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Probable Sepsis</u>                                                                                                                                                                                                                                                                                                         |  |                                                                                                       |  |                                                                                                                                                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.                                                                                                                                                                                                                               |  |                                                                                                       |  |                                                                                                                                                          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                      |  | 20a. AUTOPSY?                                                                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                       |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                   |  | P.M. 19                                                                                               |  |                                                                                                                                                          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                       |  |                                                                                                                                                          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-8</u> , 19 <u>82</u> , to <u>9-16</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>9-16</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                       |  |                                                                                                                                                          |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                    |  | DEGREE                                                                                                |  | 22c. DATE SIGNED                                                                                                                                         |  |
| <u>A. Vento</u>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                       |  | 9-16-1982                                                                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                             |  | 22e. ADDRESS                                                                                          |  |                                                                                                                                                          |  |
| A. Vento                                                                                                                                                                                                                                                                                                                                                          |  | Luthern Hosp                                                                                          |  |                                                                                                                                                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE                                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  |
| Burial                                                                                                                                                                                                                                                                                                                                                            |  | 9-24-82                                                                                               |  | MT. ZION CEM                                                                                                                                             |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                         |  | 25a. DATE REC'D. BY REGISTRAR                                                                         |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                               |  |
| BROWN-Thompson E.L.                                                                                                                                                                                                                                                                                                                                               |  | 1913 W. BALTA ST                                                                                      |  | SEP 23 1982 John J. Carver                                                                                                                               |  |



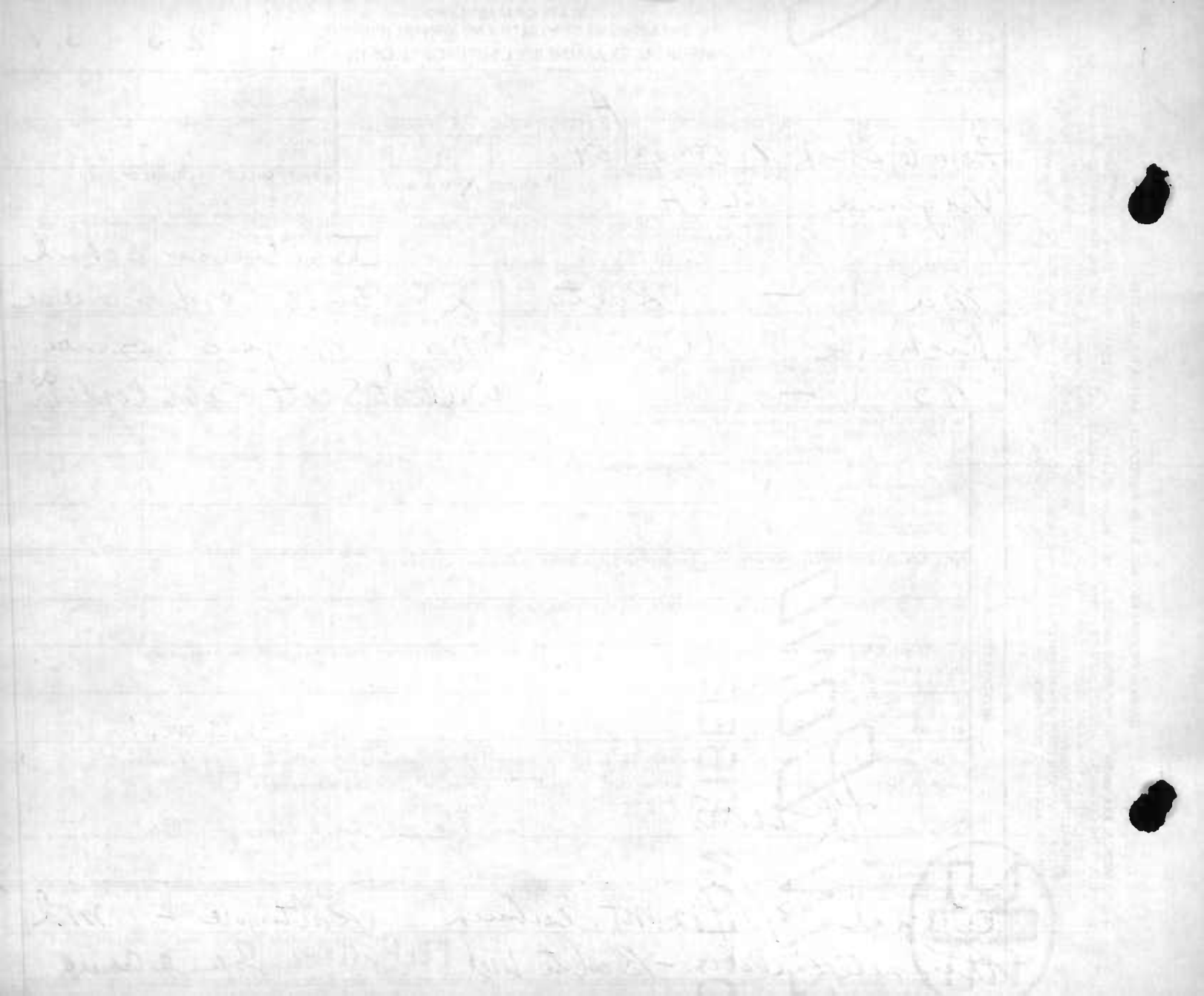


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                  |  |  |  |                                                                                    |  |  |  |                                                                                               |  | REG. NO. 8 2 2 3 4 5 7                                                                          |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|------------------------------------------------------------------------------------|--|--|--|-----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |  |                                                                                    |  |  |  |                                                                                               |  |                                                                                                 |  |
| 1. DECEASED NAME (TYPE OR PRINT) Elizabeth A Scott                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |                                                                                    |  |  |  |                                                                                               |  | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 16 19 82 |  |
| 3. SEX Female 4. RACE Black 5. DATE OF BIRTH 1 5 23 59 YRS. 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS. 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 2c. DATE PRONOUNCED DEAD 9 16 19 82 2d. HOUR 11: A                                       |  |  |  |                                                                                    |  |  |  |                                                                                               |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.                                         |  |
| 10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Janitor/ess 12b. KIND OF BUSINESS OR INDUSTRY School                                                                                                                                                            |  |  |  |                                                                                    |  |  |  |                                                                                               |  |                                                                                                 |  |
| 13a. STATE md 13b. COUNTY - 13c. CITY OR TOWN Balto 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 5266 Cordelia ave                                                                                                                                                                                                                                                   |  |  |  |                                                                                    |  |  |  |                                                                                               |  |                                                                                                 |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Richard Wormley 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Maggie Berry                                                                                                                                                                                                                                                                                                                         |  |  |  |                                                                                    |  |  |  |                                                                                               |  |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No 16b. SOCIAL SECURITY No 17. INFORMANT Willist. Scott 5266 Cordelia ave                                                                                                                                                                                                                                                                                              |  |  |  |                                                                                    |  |  |  |                                                                                               |  |                                                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Fracture cervical spine<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                               |  |  |  |                                                                                    |  |  |  |                                                                                               |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                                                                                                                                                                                                                                           |  |  |  |                                                                                    |  |  |  |                                                                                               |  |                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                         |  |                                                                                                 |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 4: P P.M. 9/9 1982                                                                                                                                                                                                                                                                                                   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR approx 4: P P.M. 9/9 1982             |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) fell from porch |  |                                                                                                 |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home                                                                                                                                                                                                                                                       |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5266 Cordelia Avenue, Baltimore, MD |  |  |  |                                                                                               |  |                                                                                                 |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |                                                                                    |  |  |  |                                                                                               |  |                                                                                                 |  |
| ACTUAL SIGNATURE H. Guard                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER                                    |  |  |  | DATE SIGNED 9/17/82                                                                           |  |                                                                                                 |  |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  | ADDRESS 111 Penn Street, Balto. MD 21201                                           |  |  |  |                                                                                               |  |                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL Burial                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |  | 23b. DATE 9/21/82                                                                  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY Mt Auburn                                                  |  |                                                                                                 |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore - md                                                                                                                                                                                                                                                                                                                                                                                   |  |  |  |                                                                                    |  |  |  |                                                                                               |  |                                                                                                 |  |
| 24. FUNERAL DIRECTOR (NAME) Cuenell B. Oden - Balto. Md.                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  | 25a. DATE REC'D. BY REGISTRAR SEP 20 1982                                          |  |  |  | 25b. REGISTRAR'S SIGNATURE John J. Conner                                                     |  |                                                                                                 |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must file the findings of burial.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                   |  | 8 2 2 3 4 5 8                                                                                                                                            |  |                                                                                                                         |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                   |  | REG. NO.                                                                                                                                                 |  |                                                                                                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>ROSALee SCOTT</b>                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                   |  | 2a. DATE OF DEATH MONTH DAY YEAR 9 16 82                                                                                                                 |  |                                                                                                                         |  |
| 3 SEX <b>female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                   |  | 2b. HOUR 10:30 P                                                                                                                                         |  |                                                                                                                         |  |
| 4. RACE <b>BLACK</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 5. DATE OF BIRTH MONTH DAY YEAR 2 24 90                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS                                                                                                                   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South CAR.</b>                                                                                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY? <b>US</b>                                                                                            |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                                                          |  |
| 10. CITY OR TOWN OF DEATH <b>Balto</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PLEASANT MANOR N.H.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                   |  | 13a. STREET ADDRESS                                                                                                                                      |  |                                                                                                                         |  |
| 13a. STATE <b>md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 13b. COUNTY                                                                                                                       |  | 13c. CITY OR TOWN <b>Balto.</b>                                                                                                                          |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Carter</b>                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Louisa Ford</b>                                                                                            |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO. <b>999-90-7438</b>                                                                                       |  | 17. INFORMANT ADDRESS <b>4615 Pk. Hghts. Ave. Balto. Md. 21215</b>                                                                                       |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Generalized, severe arteriosclerosis</b><br><b>4409</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b> |  |                                                                                                                                   |  |                                                                                                                                                          |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic Bmleutis - 6 mos</b>                                                                                                                                                                                                                                                                               |  |                                                                                                                                   |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                               |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-1</b> , 19 <b>82</b> , to <b>9/16</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>9/16</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                  |  |                                                                                                                                   |  |                                                                                                                                                          |  |                                                                                                                         |  |
| 22b. SIGNATURE <b>Jaime Punzalan</b> DEGREE                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED <b>9/17/82</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAIME PUNZALAN</b>                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                   |  | 22e. ADDRESS <b>5214 Harford Rd. Balt. Md.</b>                                                                                                           |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE <b>9-22-82</b>                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEM. PK.</b>                                                                                               |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>                                                       |  |
| 24. FUNERAL DIRECTOR NAME <b>E.L. PHILLIPS</b> <b>1721 N. MONROE ST.</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                   |  | 25a. DATE REC'D. BY REGISTRAR <b>SEP 23 1982</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE <b>Joan L. Connel</b>                                                                        |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or other qualified person should be consulted.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                            |  | 8 2 2 3 4 5 9                                |  |                                                                                                                            |  |      |  |            |  |  |  |       |  |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|------|--|------------|--|--|--|-------|--|--|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                              |  | REG. NO.                                                                                                  |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                            |  |                                              |  |                                                                                                                            |  |      |  |            |  |  |  |       |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                 |  | FIRST                                                                                                     |  | MIDDLE                                                                                                                                                      |  | LAST                                                                                            |  | 2a. DATE OF DEATH                                                                                                                          |  | MONTH                                        |  | DAY                                                                                                                        |  | YEAR |  | 2b. HOUR   |  |  |  |       |  |  |  |
| Edwin M Seabolt                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                                 |  | 09 07 82                                                                                                                                   |  |                                              |  |                                                                                                                            |  |      |  | 1:42 AM    |  |  |  |       |  |  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE                                                                                                   |  | 5. DATE OF BIRTH                                                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                 |  | IF UNDER 1 YEAR                                                                                                                            |  | IF UNDER 24 HRS.                             |  | MONTHS                                                                                                                     |  | DAYS |  | HOURS MIN. |  |  |  |       |  |  |  |
| Male                                                                                                                                                                                                                                                                                                                                                |  | Caucasian                                                                                                 |  | 02 21 18                                                                                                                                                    |  | 64 YRS.                                                                                         |  |                                                                                                                                            |  |                                              |  |                                                                                                                            |  |      |  |            |  |  |  |       |  |  |  |
| 7. BIRTHPLACE<br>(COUNTRY)                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                            |  |                                                                                                                                            |  |                                              |  |                                                                                                                            |  |      |  |            |  |  |  |       |  |  |  |
| Pa                                                                                                                                                                                                                                                                                                                                                  |  | USA                                                                                                       |  |                                                                                                                                                             |  | Balt. City MD.                                                                                  |  |                                                                                                                                            |  |                                              |  |                                                                                                                            |  |      |  |            |  |  |  |       |  |  |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |  |                                                                                                                                            |  |                                              |  |                                                                                                                            |  |      |  |            |  |  |  |       |  |  |  |
| Balt.                                                                                                                                                                                                                                                                                                                                               |  | SBGH                                                                                                      |  | Wireman                                                                                                                                                     |  | B & E Co.                                                                                       |  |                                                                                                                                            |  |                                              |  |                                                                                                                            |  |      |  |            |  |  |  |       |  |  |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                          |  | 13b. COUNTY                                                                                               |  | 13c. CITY OR TOWN                                                                                                                                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS                                                                                                                        |  |                                              |  |                                                                                                                            |  |      |  |            |  |  |  |       |  |  |  |
| Md                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  | Balt.                                                                                                                                                       |  |                                                                                                 |  | 1419 Filbert St.                                                                                                                           |  |                                              |  |                                                                                                                            |  |      |  |            |  |  |  |       |  |  |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME                                                                                  |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                            |  |                                              |  |                                                                                                                            |  |      |  |            |  |  |  |       |  |  |  |
| Michael Seabolt                                                                                                                                                                                                                                                                                                                                     |  | Mary Jane Roberts                                                                                         |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                            |  |                                              |  |                                                                                                                            |  |      |  |            |  |  |  |       |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE DATES)                                                          |  | 17. INFORMANT                                                                                                                                               |  |                                                                                                 |  |                                                                                                                                            |  |                                              |  |                                                                                                                            |  |      |  |            |  |  |  |       |  |  |  |
| Yes                                                                                                                                                                                                                                                                                                                                                 |  | 194-03-7977                                                                                               |  | Veronica A. Seabolt                                                                                                                                         |  | Same as #13                                                                                     |  |                                                                                                                                            |  |                                              |  |                                                                                                                            |  |      |  |            |  |  |  |       |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>4100 IMMEDIATE CAUSE (a) Pulmonary edema & congestion<br>DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction, Antero-lateral aspect of left ventricle<br>DUE TO, OR AS A CONSEQUENCE OF (c) Coronary atherosclerotic disease |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                            |  |      |  |            |  |  |  |       |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Generalized atherosclerosis, Severe                                                                                                                                                                            |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                            |  |                                              |  |                                                                                                                            |  |      |  |            |  |  |  |       |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                              |  |                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                                                                 |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |  |                                              |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |      |  |            |  |  |  |       |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                            |  |                                              |  |                                                                                                                            |  |      |  |            |  |  |  |       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                            |  |                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |  |                                                                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |  |                                              |  |                                                                                                                            |  |      |  |            |  |  |  |       |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                            |  |                                              |  |                                                                                                                            |  |      |  |            |  |  |  |       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                           |  |                                                                                                           |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE, FARM, ETC.)                                                                                         |  |                                                                                                 |  | 21f. LOCATION<br>STREET                                                                                                                    |  |                                              |  | CITY OR TOWN                                                                                                               |  |      |  | COUNTY     |  |  |  | STATE |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                            |  |                                              |  |                                                                                                                            |  |      |  |            |  |  |  |       |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from 9/7 1982, to 9/7 1982, that (we) lost (the deceased) on 9/7 1982, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.                                                                        |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                            |  |                                              |  |                                                                                                                            |  |      |  |            |  |  |  |       |  |  |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                           |  | DEGREE                                                                                                                                                      |  |                                                                                                 |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                                              |  | 22c. DATE SIGNED                                                                                                           |  |      |  |            |  |  |  |       |  |  |  |
| George Vallecillo, MD                                                                                                                                                                                                                                                                                                                               |  |                                                                                                           |  | MD                                                                                                                                                          |  |                                                                                                 |  |                                                                                                                                            |  |                                              |  | 9/7/82                                                                                                                     |  |      |  |            |  |  |  |       |  |  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                               |  |                                                                                                           |  | 22e. ADDRESS                                                                                                                                                |  |                                                                                                 |  |                                                                                                                                            |  |                                              |  |                                                                                                                            |  |      |  |            |  |  |  |       |  |  |  |
| George Vallecillo                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                           |  | SBGH                                                                                                                                                        |  |                                                                                                 |  |                                                                                                                                            |  |                                              |  |                                                                                                                            |  |      |  |            |  |  |  |       |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)                                                                                                                                                                                                                                                                                                           |  |                                                                                                           |  | 23b. DATE                                                                                                                                                   |  |                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                         |  |                                              |  | 23d. LOCATION<br>CITY OR TOWN                                                                                              |  |      |  | COUNTY     |  |  |  | STATE |  |  |  |
| Burial                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                           |  | 9/10/82                                                                                                                                                     |  |                                                                                                 |  | Holy Cross Cemetery                                                                                                                        |  |                                              |  | Baltimore, A. Co., Md.                                                                                                     |  |      |  |            |  |  |  |       |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                        |  |                                                                                                           |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                               |  |                                                                                                 |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                 |  |                                              |  |                                                                                                                            |  |      |  |            |  |  |  |       |  |  |  |
| McCully Funeral Home                                                                                                                                                                                                                                                                                                                                |  |                                                                                                           |  | SEP 9 1982                                                                                                                                                  |  |                                                                                                 |  | John J. Connel                                                                                                                             |  |                                              |  |                                                                                                                            |  |      |  |            |  |  |  |       |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Final cause may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or after traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 4 6 0

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                               |                                                                 |                                                                                                                                                              |  |                                                                                          |  |                                                                                                            |                                                                 |                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Ethel Virginia Seabrease</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                               | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 2, 1982</b> |                                                                                                                                                              |  | 2b. HOUR<br><b>6:10P M</b>                                                               |  |                                                                                                            |                                                                 |                                                                                                                            |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br><b>White</b>                                                                                                                       |                                                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 12 21</b>                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS.                                        |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>60</b>                                                             |                                                                 | 7. IF UNDER 24 HRS.<br>HOURS MIN.<br><b>60</b>                                                                             |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 9. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                  |                                                                 | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                       |  |                                                                                                            |                                                                 |                                                                                                                            |  |
| 12. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |                                                                 |                                                                                                                                                              |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Cafeteria cook</b> |  |                                                                                                            | 15. KIND OF BUSINESS OR INDUSTRY<br><b>Balt. Co. Schools</b>    |                                                                                                                            |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                               |                                                                 | 17. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                               |  |                                                                                          |  | 18. STREET ADDRESS<br><b>4812 Deer Park Rd. 21117</b>                                                      |                                                                 |                                                                                                                            |  |
| 19. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 20. COUNTY<br><b>Baltimore</b>                                                                                                                |                                                                 | 21. CITY OR TOWN<br><b>Owings Mills</b>                                                                                                                      |  | 22. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Bidinger</b>                           |  |                                                                                                            |                                                                 |                                                                                                                            |  |
| 23. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Ziegler</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 24. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No -</b>                                |                                                                 |                                                                                                                                                              |  | 25. SOCIAL SECURITY NO.<br><b>218-22-7740</b>                                            |  | 26. INFORMANT<br>ADDRESS<br><b>Mr. Richard Seabrease 21117<br/>44 Garrison Ridge Ct., Owings Mills, MD</b> |                                                                 |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1519 IMMEDIATE CAUSE (a) Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Esophagojejunal Fistula with Leakage</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Gastric Lymphoma with Metastasis</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b><br><b>3 months</b> |  |                                                                                                                                               |                                                                 |                                                                                                                                                              |  |                                                                                          |  |                                                                                                            |                                                                 |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                               |                                                                 |                                                                                                                                                              |  |                                                                                          |  |                                                                                                            |                                                                 |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                               |                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                             |  |                                                                                          |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                       |                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                               |                                                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                            |  |                                                                                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                             |                                                                 |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                               |                                                                 | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                       |  |                                                                                          |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                          |                                                                 |                                                                                                                            |  |
| 22a. I certify that this hospital attended the deceased from <b>July 6, 1982</b> , to <b>September 2, 1982</b> , that (X) we last saw the deceased alive on <b>September 2, 1982</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.                                                                                                                                                                                 |  |                                                                                                                                               |                                                                 |                                                                                                                                                              |  |                                                                                          |  |                                                                                                            |                                                                 |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Linda J. Rever</b> DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                               |                                                                 |                                                                                                                                                              |  |                                                                                          |  | 22c. DATE SIGNED<br><b>9/2/82</b>                                                                          |                                                                 |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Linda Rever, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                               |                                                                 |                                                                                                                                                              |  |                                                                                          |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>                                                       |                                                                 |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                               |                                                                 | 23b. DATE<br><b>9/7/82</b>                                                                                                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Evergreen Memorial Gds, Finksburg</b>           |  |                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Carroll MD</b> |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Loring Byers Funeral Directors, Inc.<br/>8728 Liberty Road Randallstown, MD. 21133</b>                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                               |                                                                 |                                                                                                                                                              |  |                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 7 1982</b>                                                         |                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                                                        |  |

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 2 3 4 6 1  
REG. NO.

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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GLADYS M SEAL</b>                                                                                                                                                                                                                     |                                               | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 20 82</b>                                                                                                                                                                                                                                                                                               |  | 2b. HOUR<br>MIN.<br><b>12 A.</b>                                                     |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                      | 4. RACE<br><b>Caucasian</b>                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 28 21</b>                                                                                                                                                                                                                                                                                                |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                                                                                                                                                      | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                |                                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI Hospital</b>                                                                                                                                                                                                                  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Nurse</b>     |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Government</b>                                                                                                                                                                                                                       |                                               | 13a. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                     |  | 13b. STREET ADDRESS<br><b>14-2 Gaither Manor Dr.</b>                                 |  |
| 13c. CITY OR TOWN<br><b>Sykesville</b>                                                                                                                                                                                                                                       |                                               | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Reaver</b>                                                                                                                                                                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Viola Gamber</b>                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                            |                                               | 16b. SOCIAL SECURITY NO.<br><b>217 03 5556</b>                                                                                                                                                                                                                                                                                                      |  | 17. INFORMANT<br>ADDRESS<br><b>Major Seal - Sykesville, Md.</b>                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chr. Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>COPD</b> |                                               |                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                           |                                               |                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                      |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                       |                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                    |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                   |                                               | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                             |  |                                                                                      |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                                                                                                                                   |                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                                                                                                                                      |  |                                                                                      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                 |                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                                              |  |                                                                                      |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                            |                                               | 22a. I certify that (I) (this hospital) attended the deceased from <b>July 15, 1982</b> to <b>Sept 20, 1982</b> , that (I) (we) lost<br>saw the deceased alive on <b>Sept 20, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death. |  |                                                                                      |  |
| 22b. SIGNATURE<br><b>D. Patel 9061</b>                                                                                                                                                                                                                                       |                                               | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                                                                                                                                                                                      |  | 22c. DATE SIGNED<br><b>9.20.82</b>                                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D.S. PATEL</b>                                                                                                                                                                                                                   |                                               | 22e. ADDRESS<br><b>SINAI HOSPITAL</b>                                                                                                                                                                                                                                                                                                               |  |                                                                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>                                                                                                                                                                                                                             |                                               | 23b. DATE<br><b>9-22-82</b>                                                                                                                                                                                                                                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Croftdown Cemetery</b>                      |  |
| 23d. LOCATION<br>OR TOWN COUNTY STATE<br><b>Marysville Carroll Md.</b>                                                                                                                                                                                                       |                                               | 23e. DATE REC'D. BY REGISTRAR<br><b>SEP 20 1982</b>                                                                                                                                                                                                                                                                                                 |  |                                                                                      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Harry W. Haight</b>                                                                                                                                                                                                                       |                                               | ADDRESS<br><b>Sykesville, Md.</b>                                                                                                                                                                                                                                                                                                                   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conish</b>                                  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before removal of the body.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                    |  |                                                                                                                                                              |  |                                                                                      |  |                                                                                                                               |  | 7 2 2 3 4 6 2                                   |  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | REG. NO.                                                                                                                           |  |                                                                                                                                                              |  |                                                                                      |  |                                                                                                                               |  |                                                 |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ANNA A.GNES SEISMAN                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                    |  |                                                                                                                                                              |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>SEPTEMBER 11, 82                              |  | 2b. HOUR<br>1:00am                                                                                                            |  |                                                 |  |  |  |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br>WHITE                                                                                                                   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MAY 30, 1896                                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS.                                           |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                             |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.               |  |  |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NEW JERSEY                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 9b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                             |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |                                                                                                                               |  |                                                 |  |  |  |
| 11. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>CHURCH HOSPITAL, INC. |  |                                                                                                                                                              |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER        |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                             |  |                                                 |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                    |  | 13b. COUNTY<br>BALTO.                                                                                                                                        |  | 13c. CITY OR TOWN<br>DUNDALK                                                         |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |  | 13e. STREET ADDRESS<br>2 LEEWAY 21222           |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>GEORGE MURRAY                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARGARET VEDUN                                                                                              |  |                                                                                      |  |                                                                                                                               |  |                                                 |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.<br>216.03.7975D                                                                                                                     |  | 17. INFORMANT<br>ADDRESS<br>JACK J. SEISMAN 571 S. 47th ST.<br>BALTIMORE, MD. 21224  |  |                                                                                                                               |  |                                                 |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>4280 IMMEDIATE CAUSE (a) Cerebrovascular accident with decubitus<br>ULCERS } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which } (b) CONGESTIVE HEART FAILURE<br>gave rise to immediate }<br>cause (a), stating the }<br>underlying cause last }<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a |  |                                                                                                                                    |  |                                                                                                                                                              |  |                                                                                      |  |                                                                                                                               |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |  |                                                                                                                                                              |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                 |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                               |  |                                                                                      |  |                                                                                                                               |  |                                                 |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                             |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                            |  |                                                                                      |  |                                                                                                                               |  |                                                 |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-6-29, 19-82, to 9-11, 19-82, that (I) (we) last saw the deceased alive on 9-11, 19-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did) (and not view) the body after death.                                                                                                                                                                                                 |  |                                                                                                                                    |  |                                                                                                                                                              |  |                                                                                      |  |                                                                                                                               |  |                                                 |  |  |  |
| 22b. SIGNATURE<br>Walker Impagiliatelli                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                    |  |                                                                                                                                                              |  | DEGREE                                                                               |  | 22c. DATE SIGNED<br>9/11/82                                                                                                   |  |                                                 |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WALKER IMPAGILIATELLI                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                    |  |                                                                                                                                                              |  | 22e. ADDRESS<br>CHURCH HOME HOSPITAL 100 N.<br>BROADWAY BALTIMORE, MD. 21231         |  |                                                                                                                               |  |                                                 |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br>9.15/1982                                                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br>SACRED HEART OF JESUS                                                                                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>DUNDALK BALTO. MD.                     |  |                                                                                                                               |  |                                                 |  |  |  |
| 24. FUNERAL DIRECTOR<br>WALTER BROOKS BRADLEY INC., DUNDALK, MD. 21222                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                    |  |                                                                                                                                                              |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 15 1982                                         |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel                                                                                  |  |                                                 |  |  |  |

STANDARD INDUSTRIAL LITHOGRAPH CO.  
NEW YORK, N. Y.

NEW YORK CITY

UNITED STATES, INC.

2111

NOTES



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 4 6 3

FOR  
STATE  
REGISTRAR

REG. NO.

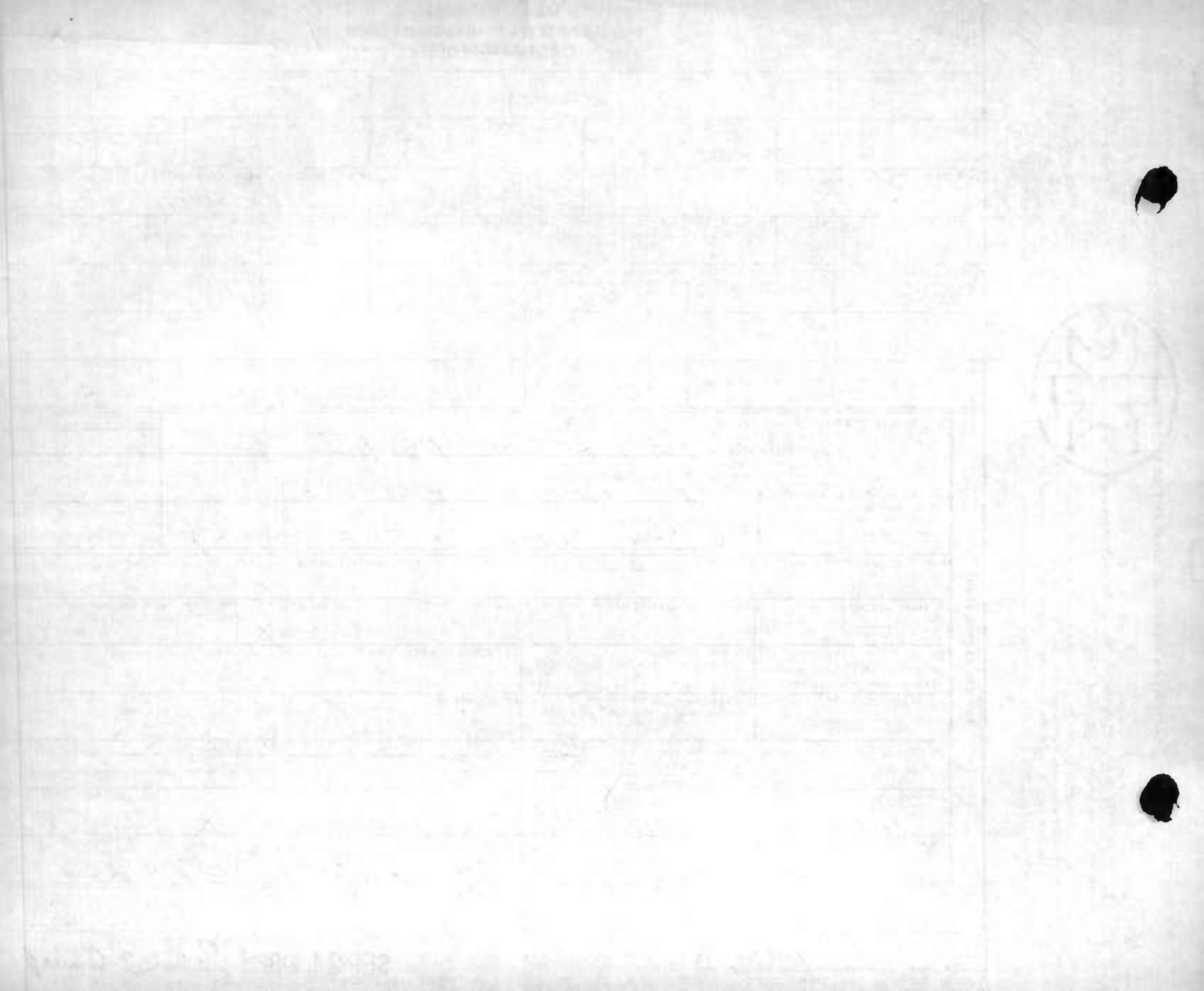
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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOSEPH</b>                                                                                                                                                                                                                                                                                                                                                                     |  | FIRST<br><b>SEMBLY</b>                                                                                                                               |  | LAST<br><b>SEMBLY</b>                                                                                                                                       |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 17 1982</b>                                         |  | 2b. HOUR<br><b>M</b>                                                                                                       |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br><b>Negro</b>                                                                                                                              |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 1 05</b>                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                                                                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.                              |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b>                   |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                            |  | 13b. COUNTY                                                                                                                                          |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3314 Burleith Avenue</b>                                                                         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John</b>                                                                                                                                                                                                                                                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary</b>                                                                                         |  |                                                                                                                                                             |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>                  |  |                                                                                                                            |  |
| 16b. SOCIAL SECURITY NO.<br><b>220-14-8658</b>                                                                                                                                                                                                                                                                                                                                                                           |  | 17. INFORMANT<br><b>Maxine M. Sembly</b>                                                                                                             |  |                                                                                                                                                             |  | ADDRESS<br><b>3314 Burleith Avenue</b>                                                          |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br><b>1890</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PULMONARY METASTASES</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CARCINOMA OF THE KIDNEY</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION<br><b>7/29/82</b>                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                     |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                                 |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                               |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JULY 1982</b> to <b>30 AUGUST 1982</b> , that (I) (we) lost<br>saw the deceased alive on <b>30 AUGUST 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                       |  |                                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Edward W. Campbell, MD</b>                                                                                                                                                                                                                                                                                                                                                                          |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                                                                                                                                                             |  | 22c. DATE SIGNED<br><b>9/18/82</b>                                                              |  |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>EW CAMPBELL</b>                                                                                                                                                                                                                                                                                                                                                              |  | 22e. ADDRESS<br><b>UNIVERSITY HOSPITAL</b>                                                                                                           |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                            |  | 23b. DATE<br><b>9/23/82</b>                                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>                                                                                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus, Md.</b>                               |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 21 1982</b>                                                                        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WM. C. MARCH F/H INC. 1101 E. NORTH AVENUE</b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                      |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                                                                                         |  |                                                                                                 |  |                                                                                                                            |  |

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16-50M 1/B1  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                     |  |                                                                                                                         |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR <b>Louise E. Seng</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                     |  |                                                                                                                         |  |
| 1. DECEASED NAME (FIRST MIDDLE LAST)<br><b>LOUISE EULALIA SENG</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                             |  |                                                                                                                                                             |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>09 03 82</b>                                 |  | 2b. HOUR<br><b>0604</b>                                                                                                 |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE<br><b>White</b>                                                                                                                     |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10 10 15</b>                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.                                   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                               |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                   |  |                                                                                                                         |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>So. Baltimore General Hosp</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesperson</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Avon Cosmetics</b>                                                              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY<br><b>Md. A.A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                             |  |                                                                                                                                                             |  | 13b. CITY OR TOWN<br><b>Brooklyn</b>                                                |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Joseph E. Michno</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                             |  |                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Ann Twardowska</b>            |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br><b>219 38 8846</b>                                                                                              |  | 17. INFORMANT ADDRESS<br><b>Frederick Seng same as 13 e</b>                                                                                                 |  |                                                                                     |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <b>Acute myocardial infarction, left Ventricle</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary artery disease, severe</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized arteriosclerosis, severe</b><br>PART 2* OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Hypertensive disease (Cardiomegaly, nephroarteriosclerosis)</b> |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                     |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                            |  |                                                                                                                                                             |  | 20a. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>               |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                     |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                         |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                     |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/3</b> , 19 <b>82</b> , to <b>9/3</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                                                              |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                     |  |                                                                                                                         |  |
| 22b. SIGNATURE OF PHYSICIAN<br><b>Alex Hertzman</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                             |  |                                                                                                                                                             |  | DEGREE<br><b>MD</b>                                                                 |  | 22c. DATE SIGNED<br><b>9/3/82</b>                                                                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Alex HERTZMAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                             |  |                                                                                                                                                             |  | 22e. ADDRESS<br><b>3001 S. FLANOVER ST.</b>                                         |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 23b. DATE<br><b>9/7/82</b>                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Veterans Cem</b>                                                                                               |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Crownsville, Maryland</b>             |  |                                                                                                                         |  |
| 24. FUNERAL DIRECTOR NAME<br><b>George J. Gonce</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                             |  |                                                                                                                                                             |  | BALTO. MD. ADDRESS<br><b>4001 Ritchie Hgwy 21225</b>                                |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 7 1982</b>                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                             |  |                                                                                                                                                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                 |  |                                                                                                                         |  |

MEDICAL CERTIFICATION



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STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

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REG. NO.

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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                          |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                                                                                                 | 2b. HOUR                                                       |                                              |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                |                                                                                                        | MONTH DAY YEAR                                                                                                                                           |                                                                                                                                 | M                                                              |                                              |
| JOSEPH S. SERIO                                                                                                                                                                                                                                                                                 |                                                                                                        | 09 19 82                                                                                                                                                 |                                                                                                                                 |                                                                |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                          | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                                 | IF UNDER 1 YEAR                                                |                                              |
| MALE                                                                                                                                                                                                                                                                                            | WHITE                                                                                                  | MONTH DAY YEAR                                                                                                                                           | 72 YRS.                                                                                                                         | IF UNDER 24 HRS                                                |                                              |
|                                                                                                                                                                                                                                                                                                 |                                                                                                        | 12 15 09                                                                                                                                                 |                                                                                                                                 | MONTHS DAYS HOURS MIN.                                         |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                       | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                            |                                                                |                                              |
| MARYLAND                                                                                                                                                                                                                                                                                        | U.S.A.                                                                                                 |                                                                                                                                                          | BALTIMORE CITY MD.                                                                                                              |                                                                |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                               |                                                                |                                              |
| BALTIMORE                                                                                                                                                                                                                                                                                       | 401 YALE AVENUE, 21229                                                                                 | ASSEMBLY                                                                                                                                                 | AUTOMOBILE                                                                                                                      |                                                                |                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                      | 13b. COUNTY                                                                                            | 13c. CITY OR TOWN                                                                                                                                        | 13d. INSIDE CITY LIMITS?                                                                                                        | 13e. STREET ADDRESS                                            |                                              |
| MARYLAND                                                                                                                                                                                                                                                                                        | ---                                                                                                    | BALTIMORE                                                                                                                                                | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             | 401 YALE AVENUE, 21229                                         |                                              |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)                                                                                                                                                                                                                                                           | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)                                                           | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                                                            |                                                                                                                                 |                                                                |                                              |
| COSMAS                                                                                                                                                                                                                                                                                          | SERIO                                                                                                  | 16b. SOCIAL SECURITY NO.                                                                                                                                 |                                                                                                                                 |                                                                |                                              |
|                                                                                                                                                                                                                                                                                                 |                                                                                                        | 216-01-5019                                                                                                                                              |                                                                                                                                 |                                                                |                                              |
| 17. INFORMANT                                                                                                                                                                                                                                                                                   |                                                                                                        | ADDRESS                                                                                                                                                  |                                                                                                                                 |                                                                |                                              |
| SAM A. PRESTI                                                                                                                                                                                                                                                                                   |                                                                                                        | 4320 HIGHVIEW AVE., 21229                                                                                                                                |                                                                                                                                 |                                                                |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                          |                                                                                                                                 |                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 4100                                                                                                                                                                                                                                                                                            |                                                                                                        |                                                                                                                                                          |                                                                                                                                 |                                                                |                                              |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                          |                                                                                                                                 |                                                                |                                              |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                          |                                                                                                                                 |                                                                |                                              |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                          |                                                                                                                                 |                                                                |                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a                                                                                                                                                               |                                                                                                        |                                                                                                                                                          |                                                                                                                                 |                                                                |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                          |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         | 20a. AUTOPSY?                                                                                                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                              |
|                                                                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                              | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                            |                                                                                                                                 |                                                                |                                              |
|                                                                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                          |                                                                                                                                 |                                                                |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                          | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION CITY OR TOWN COUNTY STATE                                                                                                                  |                                                                                                                                 |                                                                |                                              |
|                                                                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                          |                                                                                                                                 |                                                                |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 12 to 19 82, that (I) (we) last saw the deceased alive on 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                        |                                                                                                                                                          |                                                                                                                                 |                                                                |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                  |                                                                                                        | DEGREE                                                                                                                                                   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                | 22c. DATE SIGNED                             |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                           |                                                                                                        | 22e. ADDRESS                                                                                                                                             |                                                                                                                                 |                                                                |                                              |
| EIMO M. GAYOSO, M.D.                                                                                                                                                                                                                                                                            |                                                                                                        | 5411 OLD FREDERICK ROAD, SUITE 8 21229                                                                                                                   |                                                                                                                                 |                                                                |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                       | 23b. DATE                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                                                         |                                                                |                                              |
| BURIAL                                                                                                                                                                                                                                                                                          | 09-22-82                                                                                               | CEDAR HILL                                                                                                                                               | BROOKLYN PK. A.A. MARYLAND                                                                                                      |                                                                |                                              |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                       |                                                                                                        | 25a. DATE RECD. BY REGISTRAR                                                                                                                             | 25b. REGISTRAR'S SIGNATURE                                                                                                      |                                                                |                                              |
| HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.                                                                                                                                                                                                                                                    |                                                                                                        | 21229                                                                                                                                                    | SEP 22 1982                                                                                                                     |                                                                |                                              |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                       |  |                                                                                                                             |  |                                                                                                                                                             |                                            |                                                                                                 |  |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                             |  |                                                                                                                                                             |                                            |                                                                                                 |  |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>ANNA SEWELL                                                                                                                                                                                                                                                                                       |  |                                                                                                                             |  |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br>9 3 82 |                                                                                                 |  |                                                                                                                            |  |
| 1. SEX<br>F                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br>Black                                                                                                            |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 7 96                                                                                                               |                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85                                                           |  | 2b. HOUR<br>12:50 AM                                                                                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                         |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>City                                                    |  | MD                                                                                                                         |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lutheran Hosp. |  |                                                                                                                                                             |                                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. STATE<br>md                                                                                                                                                                                                                                                                                                                                           |  | 13b. COUNTY                                                                                                                 |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>827 N. Arlington Ave                                                                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Robert Shorter                                                                                                                                                                                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Irene Taylor                                                               |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                        |                                            |                                                                                                 |  |                                                                                                                            |  |
| 16b. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                   |  | 17. INFORMANT ADDRESS<br>Vernon Shorter - 1102 Druid Hill Ave.                                                              |  |                                                                                                                                                             |                                            |                                                                                                 |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u><br>4151<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Pulmonary embolism</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                        |  |                                                                                                                             |  |                                                                                                                                                             |                                            |                                                                                                 |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>CACHEXIA</u>                                                                                                                                                                                                      |  |                                                                                                                             |  |                                                                                                                                                             |                                            |                                                                                                 |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                            |  |                                                                                                                                                             |                                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                            |                                                                                                 |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                            |                                                                                                 |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/23</u> 19 <u>82</u> , to <u>9/3</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>9/3</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                             |  |                                                                                                                                                             |                                            |                                                                                                 |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>Eric Steckler MD                                                                                                                                                                                                                                                                                                                         |  | DEGREE                                                                                                                      |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                                            |                                                                                                 |  | 22c. DATE SIGNED<br>9/3/82                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ERIC STECKLER MD                                                                                                                                                                                                                                                                                                  |  | 22e. ADDRESS<br>Lutheran Hosp                                                                                               |  |                                                                                                                                                             |                                            |                                                                                                 |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                        |  | 23b. DATE<br>9/8/82                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Pk                                                                                                       |                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md                                      |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leroy O. Dyett                                                                                                                                                                                                                                                                                                             |  | ADDRESS<br>4600 Liberty Hgts                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 8 1982                                                                                                                 |                                            | 25b. REGISTRAR'S SIGNATURE<br>John J. Smith                                                     |  |                                                                                                                            |  |

DAVID MITCHELL

WILLIAM MITCHELL

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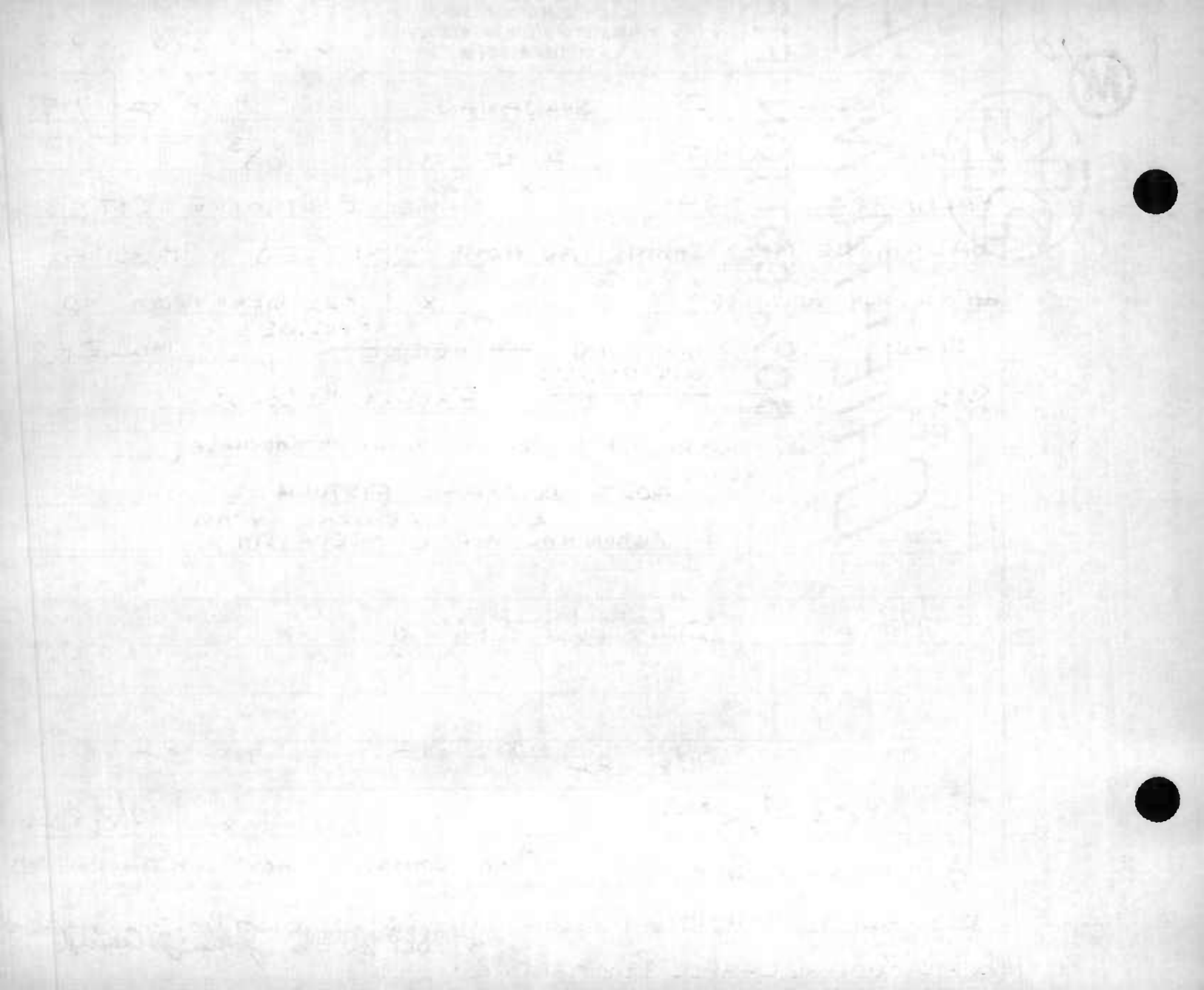
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                           |  |                                                                                                                                |  | 8 2 2 3 4 6 7<br>REG. NO.                                                                                                                                   |  |                                                                                                                         |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>JOSEPH F. SHANAHAN                                                                                                                                                                                                                                                                                       |  |                                                                                                                                |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>9 8 82                                                                                                                  |  | 2b. HOUR<br>7:00 PM                                                                                                     |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br>WHITE                                                                                                               |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>2 15 19                                                                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS<br>62 3 YRS                                                                 |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTIMORE                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                            |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                                              |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GOOD SAMARITAN HOSP. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED                                                                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>PRESSMAN                                                                           |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                         |  | 13b. CITY OR TOWN<br>BALTIMORE                                                                                                 |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                |  | 13d. STREET ADDRESS<br>1822 BERRYWOOD RD                                                                                |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>JOHN SHANAHAN                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>PAULINE KATHERINE MILLER                                                                                      |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>YES W-WII                                                                                                                                                                                                                                                     |  |                                                                                                                                |  | 17. INFORMANT ADDRESS<br>FAMILY RECORDS                                                                                                                     |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                                                                                                                                                                                                                                                                       |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                         |  |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                         |  |
| IMMEDIATE CAUSE (a) <u>MASSIVE GASTRO INTESTINAL HEMORRHAGE</u>                                                                                                                                                                                                                                                                                                |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                         |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>AORTO-DUODENAL FISTULA</u>                                                                                                                                                                                                                                                                                               |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                         |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>AORTO-BIFEMORAL BYPASS</u>                                                                                                                                                                                                                                                                                               |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                         |  |
| (c) <u>for ABDOMINAL AORTIC ANEURYSM</u>                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                           |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION<br>9/8/82                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>UPPER Gastrointestinal Bleeding<br>Aorto-Duodenal fistula                  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                             |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                            |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/8</u> 19 <u>82</u> , to <u>9/8</u> 19 <u>82</u> , that (I) (we) lost saw the deceased <u>die</u> on <u>9/8</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                         |  |
| 22b. SIGNATURE <u>[Signature]</u> DEGREE                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>9/8/82                                                                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A.O. MIREKU BOATENG                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                |  | 22e. ADDRESS<br>GOOD SAMARITAN HOSP, BALTIMORE MD                                                                                                           |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                            |  | 23b. DATE<br>9-11-1982                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Morsland Mem PK                                                                                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Parkville Balto Maryland                                                     |  |
| 24. FUNERAL DIRECTOR NAME<br>EVANS FUNERAL CHAPIN                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                |  | ADDRESS<br>8800 HARFORD                                                                                                                                     |  |                                                                                                                         |  |

SEP 20 1982





REG. NO

## MEDICAL CERTIFICATION

2004 BP \_\_\_\_\_  
DHMH - 16 50M 1/81  
52 (VRA 15, 4)



1. The first part of the document is a letter from the President of the United States to the Congress, dated January 3, 1801. It is a very important document, as it is the first time the President has addressed the Congress. The letter is written in a very formal and dignified style, and it contains many important points. The President begins by expressing his gratitude to the Congress for the honor of electing him to the office of President. He then goes on to discuss the state of the Union, and the progress of the government. He mentions the many difficulties that have been overcome, and the many successes that have been achieved. He also discusses the future of the country, and the steps that he has taken to ensure the stability and prosperity of the Union. The letter is a masterpiece of political writing, and it is a testament to the President's leadership and vision. It is a document that has stood the test of time, and it is a document that is still read and studied today.

2. The second part of the document is a letter from the Vice President of the United States to the Congress, dated January 3, 1801. It is also a very important document, as it is the first time the Vice President has addressed the Congress. The letter is written in a very formal and dignified style, and it contains many important points. The Vice President begins by expressing his gratitude to the Congress for the honor of electing him to the office of Vice President. He then goes on to discuss the state of the Union, and the progress of the government. He mentions the many difficulties that have been overcome, and the many successes that have been achieved. He also discusses the future of the country, and the steps that he has taken to ensure the stability and prosperity of the Union. The letter is a masterpiece of political writing, and it is a testament to the Vice President's leadership and vision. It is a document that has stood the test of time, and it is a document that is still read and studied today.

3. The third part of the document is a letter from the Secretary of the United States to the Congress, dated January 3, 1801. It is also a very important document, as it is the first time the Secretary has addressed the Congress. The letter is written in a very formal and dignified style, and it contains many important points. The Secretary begins by expressing his gratitude to the Congress for the honor of electing him to the office of Secretary. He then goes on to discuss the state of the Union, and the progress of the government. He mentions the many difficulties that have been overcome, and the many successes that have been achieved. He also discusses the future of the country, and the steps that he has taken to ensure the stability and prosperity of the Union. The letter is a masterpiece of political writing, and it is a testament to the Secretary's leadership and vision. It is a document that has stood the test of time, and it is a document that is still read and studied today.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHM-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 4 6 9

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                     |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 2a. DATE OF DEATH                                                                                      |  | MONTH DAY YEAR                                                                                                                                              |  | 2b. HOUR                                                            |                                              |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | FIRST MIDDLE LAST                                                                                      |  | 9 16 82                                                                                                                                                     |  | 1 P M                                                               |                                              |
| WALTER A SHEETS                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                     |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |                                              |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | White                                                                                                  |  | MONTH DAY YEAR<br>3 5 1901                                                                                                                                  |  | 81 YRS.                                                             |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                              |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | U.S.                                                                                                   |  |                                                                                                                                                             |  | Baltimore City MD.                                                  |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                                              |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | St. Agnes Hospital                                                                                     |  |                                                                                                                                                             |  |                                                                     |                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                           |  | 13d. INSIDE CITY LIMITS?                                            |                                              |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | Baltimore                                                                                              |  | Annotus                                                                                                                                                     |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                              |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME                                                                               |  | 13e. STREET ADDRESS                                                                                                                                         |  |                                                                     |                                              |
| FIRST MIDDLE LAST<br>Charles Sheets                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | FIRST MIDDLE LAST<br>Mary Simmons                                                                      |  | 5502 Sycamore Ave.                                                                                                                                          |  |                                                                     |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)                                                   |  | 17. INFORMANT                                                                                                                                               |  | ADDRESS                                                             |                                              |
| n/a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | n/a                                                                                                    |  | Lillian M. Allen                                                                                                                                            |  | 5502 Sycamore Ave. 21227                                            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest.</u><br>4360<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CVA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                        |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                     |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY?                                                                                                                                               |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                         |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                     |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                     |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                     |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                     |                                              |
| 22a. I certify that <input checked="" type="checkbox"/> (this physician) attended the deceased from <u>2/23</u> 19 <u>82</u> to <u>9/16</u> 19 <u>82</u> that (b) <input checked="" type="checkbox"/> last saw the deceased alive on <u>9/16</u> 19 <u>82</u> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (they) did not view the body after death. |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                     |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | DEGREE                                                                                                 |  | 22c. DATE SIGNED                                                                                                                                            |  |                                                                     |                                              |
| ROLANDO GONZALEZ, MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                     |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 22e. ADDRESS                                                                                           |  | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                        |  |                                                                     |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                     |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |                                              |
| burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 9/20/82                                                                                                |  | Moreland Memorial                                                                                                                                           |  | Baltimore Maryland                                                  |                                              |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | ADDRESS                                                                                                |  | 25. DATE REC'D. BY REGISTRAR                                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE                                          |                                              |
| Am brose Funeral Home                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 1328 Sulphur Sp Rd 21227                                                                               |  | SEP 20 1982                                                                                                                                                 |  | John J. Carver                                                      |                                              |

0000

BP

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

100-101100-181

100-101100-181

Items #10a-22a Film G575 1/3/83 re  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |         |                   |                                                                                                         |  |                                 |  |                                                                                                                                                          |                   |                           |  |                                                                     |                                              |          |  |                            |  |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------|-------------------|---------------------------------------------------------------------------------------------------------|--|---------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|---------------------------|--|---------------------------------------------------------------------|----------------------------------------------|----------|--|----------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                  |  |         | FIRST MIDDLE LAST |                                                                                                         |  | 2a. DATE KNOWN OF DEATH         |  |                                                                                                                                                          | xx MONTH DAY YEAR |                           |  | 2b. HOUR                                                            |                                              |          |  |                            |  |  |  |
| Phillip H. Shelton -Bey 3rd                                                                                                                                                                                                                                                                                                                                                                                                                          |  |         |                   |                                                                                                         |  | 9-27-82                         |  |                                                                                                                                                          |                   |                           |  |                                                                     |                                              |          |  |                            |  |  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE |                   | 5. DATE OF BIRTH                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY) |  | 7. IF UNDER 1 YR.                                                                                                                                        |                   | 8. IF UNDER 24 HRS.       |  | 2c. DATE PRONOUNCED DEAD                                            |                                              | 2d. HOUR |  |                            |  |  |  |
| male                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | Black   |                   | 1 14 48                                                                                                 |  | 34 YRS.                         |  |                                                                                                                                                          |                   |                           |  | 9-27-82                                                             |                                              | 6:58 PM  |  |                            |  |  |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                             |  |         |                   | 7b. CITIZEN OF WHAT COUNTRY?                                                                            |  |                                 |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                   |                           |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                              |          |  |                            |  |  |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |         |                   | USA                                                                                                     |  |                                 |  |                                                                                                                                                          |                   |                           |  | Baltimore City MD.                                                  |                                              |          |  |                            |  |  |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                            |  |         |                   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                 |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |                   |                           |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                                              |          |  |                            |  |  |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |         |                   | 1781 Montpelier Street                                                                                  |  |                                 |  |                                                                                                                                                          |                   |                           |  |                                                                     |                                              |          |  |                            |  |  |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |         |                   | 13b. COUNTY                                                                                             |  | 13c. CITY OR TOWN               |  | 13d. INSIDE CITY LIMITS?                                                                                                                                 |                   | 13e. STREET ADDRESS       |  |                                                                     |                                              |          |  |                            |  |  |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |         |                   |                                                                                                         |  | Baltimore                       |  | xx YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                   | 1781 Montpelier St. 21218 |  |                                                                     |                                              |          |  |                            |  |  |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |         |                   |                                                                                                         |  | 15. MOTHER'S MAIDEN NAME        |  |                                                                                                                                                          |                   |                           |  |                                                                     |                                              |          |  |                            |  |  |  |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |         |                   |                                                                                                         |  | FIRST MIDDLE LAST               |  |                                                                                                                                                          |                   |                           |  |                                                                     |                                              |          |  |                            |  |  |  |
| Phillip H. Shelton II                                                                                                                                                                                                                                                                                                                                                                                                                                |  |         |                   |                                                                                                         |  | Dora Robinson                   |  |                                                                                                                                                          |                   |                           |  |                                                                     |                                              |          |  |                            |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                   |  |         |                   |                                                                                                         |  | 16b. SOCIAL SECURITY NO.        |  |                                                                                                                                                          |                   |                           |  | 17. INFORMANT ADDRESS                                               |                                              |          |  |                            |  |  |  |
| No                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |         |                   |                                                                                                         |  | 218-44-4325                     |  |                                                                                                                                                          |                   |                           |  | Bernice Shelton 5507 Bowleys Lane 3C 21206                          |                                              |          |  |                            |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                                            |  |         |                   |                                                                                                         |  |                                 |  |                                                                                                                                                          |                   |                           |  |                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |  |                            |  |  |  |
| PART I DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                                                                                                          |  |         |                   |                                                                                                         |  |                                 |  |                                                                                                                                                          |                   |                           |  |                                                                     |                                              |          |  |                            |  |  |  |
| IMMEDIATE CAUSE (a) Intravenous narcotism                                                                                                                                                                                                                                                                                                                                                                                                            |  |         |                   |                                                                                                         |  |                                 |  |                                                                                                                                                          |                   |                           |  |                                                                     |                                              |          |  |                            |  |  |  |
| 3049                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |         |                   |                                                                                                         |  |                                 |  |                                                                                                                                                          |                   |                           |  |                                                                     |                                              |          |  |                            |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                                       |  |         |                   |                                                                                                         |  |                                 |  |                                                                                                                                                          |                   |                           |  |                                                                     |                                              |          |  |                            |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last                                                                                                                                                                                                                                                                                                                                                         |  |         |                   |                                                                                                         |  |                                 |  |                                                                                                                                                          |                   |                           |  |                                                                     |                                              |          |  |                            |  |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                                   |  |         |                   |                                                                                                         |  |                                 |  |                                                                                                                                                          |                   |                           |  |                                                                     |                                              |          |  |                            |  |  |  |
| (c)                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |         |                   |                                                                                                         |  |                                 |  |                                                                                                                                                          |                   |                           |  |                                                                     |                                              |          |  |                            |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                                  |  |         |                   |                                                                                                         |  |                                 |  |                                                                                                                                                          |                   |                           |  |                                                                     |                                              |          |  |                            |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                               |  |         |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                       |  |                                 |  |                                                                                                                                                          |                   |                           |  | 20. AUTOPSY?                                                        |                                              |          |  |                            |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |         |                   |                                                                                                         |  |                                 |  |                                                                                                                                                          |                   |                           |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                              |          |  |                            |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                  |  |         |                   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                            |  |                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |                   |                           |  |                                                                     |                                              |          |  |                            |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |         |                   | P.M. 19                                                                                                 |  |                                 |  |                                                                                                                                                          |                   |                           |  |                                                                     |                                              |          |  |                            |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                      |  |         |                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                             |  |                                 |  | 21f. LOCATION STREET                                                                                                                                     |                   |                           |  | CITY OR TOWN COUNTY STATE                                           |                                              |          |  |                            |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |         |                   |                                                                                                         |  |                                 |  |                                                                                                                                                          |                   |                           |  |                                                                     |                                              |          |  |                            |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |         |                   |                                                                                                         |  |                                 |  |                                                                                                                                                          |                   |                           |  |                                                                     |                                              |          |  |                            |  |  |  |
| ACTUAL SIGNATURE TITLE (SPECIFY) DATE 9-28-82                                                                                                                                                                                                                                                                                                                                                                                                        |  |         |                   |                                                                                                         |  |                                 |  |                                                                                                                                                          |                   |                           |  |                                                                     |                                              |          |  |                            |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) ADDRESS 111 Penn Street                                                                                                                                                                                                                                                                                                                                                                                              |  |         |                   |                                                                                                         |  |                                 |  |                                                                                                                                                          |                   |                           |  |                                                                     |                                              |          |  |                            |  |  |  |
| Ann M. Dixon, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |         |                   |                                                                                                         |  |                                 |  |                                                                                                                                                          |                   |                           |  |                                                                     |                                              |          |  |                            |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                            |  |         |                   | 23b. DATE                                                                                               |  |                                 |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                   |                           |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |                                              |          |  |                            |  |  |  |
| BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |         |                   | 10/4/82                                                                                                 |  |                                 |  | Eastview Mem. Pk.                                                                                                                                        |                   |                           |  | Baltimore Md.                                                       |                                              |          |  |                            |  |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                    |  |         |                   |                                                                                                         |  |                                 |  |                                                                                                                                                          |                   |                           |  | 25a. DATE REC'D. BY REGISTRAR                                       |                                              |          |  | 25b. REGISTRAR'S SIGNATURE |  |  |  |
| Wm. C. March F/ H 1101 E. North Avenue                                                                                                                                                                                                                                                                                                                                                                                                               |  |         |                   |                                                                                                         |  |                                 |  |                                                                                                                                                          |                   |                           |  | OCT 1 1982                                                          |                                              |          |  |                            |  |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE JACOBS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.





Item #5&amp;6 Film G572 10/1/82 rc

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 4 7 1

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                  |  |                                                                                      |  |                                                                                                                                            |  |                                                                   |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------|--|--------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                     |  | FIRST<br>Robert                                                                                                                        |  | MIDDLE<br>John                                                                                                                                              |  | LAST<br>SHEPPARD                                 |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>September 13, 1982                            |  |                                                                                                                                            |  | 2b. HOUR<br>2:28p<br>M                                            |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br>Black                                                                                                                       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Unknown                                                                                                               |  |                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>approx. 71<br>YRS.                                |  |                                                                                                                                            |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                    |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City<br>MD                         |  |                                                                                                                                            |  |                                                                   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |  |                                                                                                                                                             |  |                                                  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Cook (Retired)   |  |                                                                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Restaurant<br>Baltimore, Md. |  |
| 13a. STATE<br>Md                                                                                                                                                                                                                                                                                                                                        |  | 13b. COUNTY<br>Balto                                                                                                                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  |                                                  |  | 13e. STREET ADDRESS<br>1413 Madison Ave. 21217                                       |  |                                                                                                                                            |  |                                                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unknown                                                                                                    |  |                                                  |  | 16. ADDRESS<br>1701 Eutaw Place<br>Baltimore, Md 21217                               |  |                                                                                                                                            |  |                                                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Unknown                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-07-3530A                                                                |  | 17. INFORMANT<br>Mr. Millard Johnson                                                                                                                        |  |                                                  |  | 17b. ADDRESS<br>Baltimore, Md 21217                                                  |  |                                                                                                                                            |  |                                                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Sepsis<br>5902<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Right Renal Abscess<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                  |  |                                                                                      |  |                                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Arteriosclerotic cardiovascular disease; Subacute bacterial endocarditis. of the Mitral valve.                                                                                                                   |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                  |  |                                                                                      |  |                                                                                                                                            |  |                                                                   |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |  |                                                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                |  |                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |  |                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |  |                                                                                                                                            |  |                                                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                            |  |                                                                                                                                        |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  |                                                  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |                                                                                                                                            |  |                                                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from September 8, 1982, to September 13, 1982, that (X) (we) last saw the deceased alive on September 13, 1982, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did not view the body after death.                           |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                  |  |                                                                                      |  |                                                                                                                                            |  |                                                                   |  |
| 22b. SIGNATURE<br>Charles L. Ridley MD                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                  |  | DEGREE                                                                               |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>9/13/82                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Charles L. Ridley, M.D.                                                                                                                                                                                                                                                                                        |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                  |  | 22e. ADDRESS<br>c/o Maryland General Hospital                                        |  |                                                                                                                                            |  |                                                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                        |  | 23b. DATE<br>9/17/82                                                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn |  |                                                                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.                                                                                   |  |                                                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Chatman F/H 1701 McCulloch St                                                                                                                                                                                                                                                                                           |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                  |  | ADDRESS                                                                              |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 15 1982                                                                                               |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel                      |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                               |  |                                                                                                                                             |  |                                                                                                                                                                |  |                                                                                      |  |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                             |  |                                                                                                                                                                |  |                                                                                      |  |                                                                                                                            |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br><b>CLARA M. SHERWOOD</b>                                                                                                                                                                                                                                                                     |  |                                                                                                                                             |  |                                                                                                                                                                |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>9/24/82</b>                                   |  | 2b. HOUR<br><b>6<sup>26</sup> PM</b>                                                                                       |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br><b>White</b>                                                                                                                     |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>July 5, 1896</b>                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                               |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hospital</b> |  |                                                                                                                                                                |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                      |  |                                                                                                                                             |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                                |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>George Schroth</b>                                                                                                                                                                                                                                                                       |  |                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Dietz</b>                                                                                                |  |                                                                                      |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                  |  |                                                                                                                                             |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-74-0750</b>                                                                                  |  | 17. INFORMANT ADDRESS<br><b>John H. Sherwood Jr. 5128 Hillburn Ave. 21206</b>        |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4149</b> IMMEDIATE CAUSE (a) <b>CARCINO-PULMONARY CANCER</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CORONARY ARTERY DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CONGESTIVE HEART FAILURE</b>       |  |                                                                                                                                             |  |                                                                                                                                                                |  |                                                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hour</b><br><b>3+ years</b>                                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                               |  |                                                                                                                                             |  |                                                                                                                                                                |  |                                                                                      |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION<br><b>7/10/82</b>                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CONGESTIVE HEART FAILURE</b>                                                         |  |                                                                                                                                                                |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                                 |  |                                                                                      |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                      |  |                                                                                                                            |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>7/10/82</b> to <b>9/24/82</b> , that (1) (we) lost<br>saw the deceased alive on <b>7/10/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (did) (did not) view the body after death. |  |                                                                                                                                             |  |                                                                                                                                                                |  |                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Charles F. Hoesch, MD</b>                                                                                                                                                                                                                                                                                     |  |                                                                                                                                             |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                                                                                      |  | 22c. DATE SIGNED<br><b>9/24/82</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHARLES F. HOESCH, MD</b>                                                                                                                                                                                                                                                              |  |                                                                                                                                             |  | 22e. ADDRESS<br><b>9712 BELAIR RD BALTO. 21236</b>                                                                                                             |  |                                                                                      |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><b>SEP 27 1982</b>                                                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>                                                                                                 |  | 23d. LOCATION<br><b>Baltimore</b> COUNTY <b>Maryland</b> STATE                       |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc.</b> ADDRESS<br><b>Baltimore, Maryland</b>                                                                                                                                                                                                                                 |  |                                                                                                                                             |  | 25a. DATE<br><b>SEP 27 1982</b>                                                                                                                                |  | 25b. BY REGISTRAR 25c. REGISTRAR'S SIGNATURE<br><b>John J. [Signature]</b>           |  |                                                                                                                            |  |



Special Agent in Charge, Baltimore, Maryland

June 27, 1962

Baltimore

Reginald

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                         |  |                                                                                                                                 |  |                                                                                                                                                          |  |                                                                                        |  |                                                                                                                         |  | 8 2 2 3 4 7 3<br>REG. NO.                                    |  |  |  |                  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------|--|--|--|------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                 |  |                                                                                                                                                          |  |                                                                                        |  |                                                                                                                         |  | 2a. DATE OF DEATH MONTH 9 DAY 27 YEAR 82                     |  |  |  | 2b. HOUR 5:30 AM |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST <b>Felix</b> MIDDLE <b>Richard</b> LAST <b>Shimkaveg</b><br><b>FELIX SHIMKAVEG</b>                                                                                                                                                                                                                                    |  |                                                                                                                                 |  |                                                                                                                                                          |  |                                                                                        |  |                                                                                                                         |  |                                                              |  |  |  |                  |  |
| 3. SEX <b>Male</b>                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE <b>White</b>                                                                                                            |  | 5. DATE OF BIRTH MONTH 6 DAY 1 YEAR 13                                                                                                                   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.                                                |  | IF UNDER 1 YEAR MONTHS DAYS                                                                                             |  | IF UNDER 24 HRS. HOURS MIN.                                  |  |  |  |                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                         |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                         |  |                                                                                                                         |  |                                                              |  |  |  |                  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST AGNES HOSPITAL</b> |  |                                                                                                                                                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Machinist</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Repair Beth. Ship</b>                                                              |  |                                                              |  |  |  |                  |  |
| 13a. STATE <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                 |  | 13b. COUNTY <b>Baltimore</b>                                                                                                                             |  | 13c. CITY OR TOWN <b>Baltimore</b>                                                     |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 13e. STREET ADDRESS <b>1139 Wedgewood Road 21229</b>         |  |  |  |                  |  |
| 14. FATHER'S NAME FIRST <b>Felix</b> MIDDLE LAST <b>Shimkevitz</b>                                                                                                                                                                                                                                                                                           |  |                                                                                                                                 |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Helen</b> MIDDLE LAST <b>Dovidaitis</b>                                                                                |  |                                                                                        |  |                                                                                                                         |  |                                                              |  |  |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>                                                                                                                                                                                                                                                                                 |  | 16b. SOCIAL SECURITY NO. <b>WW2</b>                                                                                             |  | 17. INFORMANT <b>Elizabeth M. Shimkaveg</b>                                                                                                              |  | ADDRESS <b>Same as # 13</b>                                                            |  |                                                                                                                         |  |                                                              |  |  |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4100 IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                 |  |                                                                                                                                                          |  |                                                                                        |  |                                                                                                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b> |  |  |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____                                                                                                                                                                                                                    |  |                                                                                                                                 |  |                                                                                                                                                          |  |                                                                                        |  |                                                                                                                         |  |                                                              |  |  |  |                  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                |  |                                                                                                                                                          |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                              |  |  |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                           |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M.                                                                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                                        |  |                                                                                                                         |  |                                                              |  |  |  |                  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                             |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                        |  |                                                                                                                         |  |                                                              |  |  |  |                  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>9/25/1982</b> to <b>9/27/1982</b> , that (1) (we) lost saw the deceased alive on <b>9/26/1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.                           |  |                                                                                                                                 |  |                                                                                                                                                          |  |                                                                                        |  |                                                                                                                         |  |                                                              |  |  |  |                  |  |
| 22b. SIGNATURE <b>[Signature]</b>                                                                                                                                                                                                                                                                                                                            |  | DEGREE <b>HAALMA MD</b>                                                                                                         |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED <b>9/27/82</b>                                                        |  |                                                                                                                         |  |                                                              |  |  |  |                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Philip Halma M.D.</b>                                                                                                                                                                                                                                                                                               |  |                                                                                                                                 |  | 22e. ADDRESS <b>St. Agnes Hospital, Baltimore, Md.</b>                                                                                                   |  |                                                                                        |  |                                                                                                                         |  |                                                              |  |  |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                      |  | 23b. DATE <b>9/30/82</b>                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>                                                                                           |  | 23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY STATE <b>Md.</b>                    |  |                                                                                                                         |  |                                                              |  |  |  |                  |  |
| 24. FUNERAL DIRECTOR NAME <b>Witzke P.A.</b>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                 |  | ADDRESS <b>1630 Edmondson Avenue, Catonsville, Md. 21228</b>                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR <b>SEP 28 1982</b>                                       |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                                                                           |  |                                                              |  |  |  |                  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                              |  |                                                                                                                      |  | 8 2 2 3 4 7 4<br>REG. NO.                                                                                                                                |  |                                                                                                                         |                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                            |  |                                                                                                                      |  | 2a. DATE OF DEATH MONTH DAY YEAR 9-18-82                                                                                                                 |  |                                                                                                                         |                                              |
| 1. DECEASED NAME FIRST MIDDLE LAST WANDA B. SHORT                                                                                                                                                                                                                                                 |  |                                                                                                                      |  | 2b. HOUR 7:40 PM                                                                                                                                         |  |                                                                                                                         |                                              |
| 3. SEX Female                                                                                                                                                                                                                                                                                     |  | 4. RACE White                                                                                                        |  | 5. DATE OF BIRTH MONTH DAY YEAR 8 16 99                                                                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.                                                                                 |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Virginia                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.                                                                                  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.                                                                 |                                              |
| 10. CITY OR TOWN OF DEATH Baltimore                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hosp |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife                                                                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY ---                                                                                   |                                              |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                           |  |                                                                                                                      |  | 13a. STREET ADDRESS 317 S. Smallwood St 21223                                                                                                            |  |                                                                                                                         |                                              |
| 13a. STATE Maryland                                                                                                                                                                                                                                                                               |  | 13b. COUNTY                                                                                                          |  | 13c. CITY OR TOWN Baltimore                                                                                                                              |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank Blair                                                                                                                                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Stepp                                                            |  |                                                                                                                                                          |  |                                                                                                                         |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO. 234-10-8865D                                                                                |  | 17. INFORMANT ADDRESS 21223 Dorothy R. Smith 317 S. Smallwood Street                                                                                     |  |                                                                                                                         |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary Arrest. 4360                                                                                                                                           |  |                                                                                                                      |  |                                                                                                                                                          |  |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) CVA -                                                                                                                                                                                                                                                          |  |                                                                                                                      |  |                                                                                                                                                          |  |                                                                                                                         |                                              |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                                |  |                                                                                                                      |  |                                                                                                                                                          |  |                                                                                                                         |                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                               |  |                                                                                                                      |  |                                                                                                                                                          |  |                                                                                                                         |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                     |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                           |  |                                                                                                                         |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                          |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                         |                                              |
| 22a. I certify that I (this hospital) attended the deceased from 09-06-82 to 09-18-82, that I (we) lost saw the deceased alive on 09-18-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (do not) view the body after death. |  |                                                                                                                      |  |                                                                                                                                                          |  |                                                                                                                         |                                              |
| 22b. SIGNATURE Barry Awoke MD                                                                                                                                                                                                                                                                     |  |                                                                                                                      |  | DEGREE                                                                                                                                                   |  | 22c. DATE SIGNED 09-18-82                                                                                               |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sissy Awoke                                                                                                                                                                                                                                                 |  |                                                                                                                      |  | 22e. ADDRESS Sullivan Hospital                                                                                                                           |  |                                                                                                                         |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial                                                                                                                                                                                                                                                  |  | 23b. DATE 9/21/82                                                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery                                                                                                   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Co. Md.                                                        |                                              |
| 24. FUNERAL DIRECTOR NAME 21229 Hubbard Funeral Home, Inc. 4107 Wilkens Ave.                                                                                                                                                                                                                      |  |                                                                                                                      |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 20 1982 John J. Connel                                                                      |  |                                                                                                                         |                                              |



Wanda 2 Nov 83 83


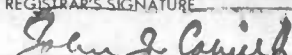
James Henry Hunt  
1951-1993

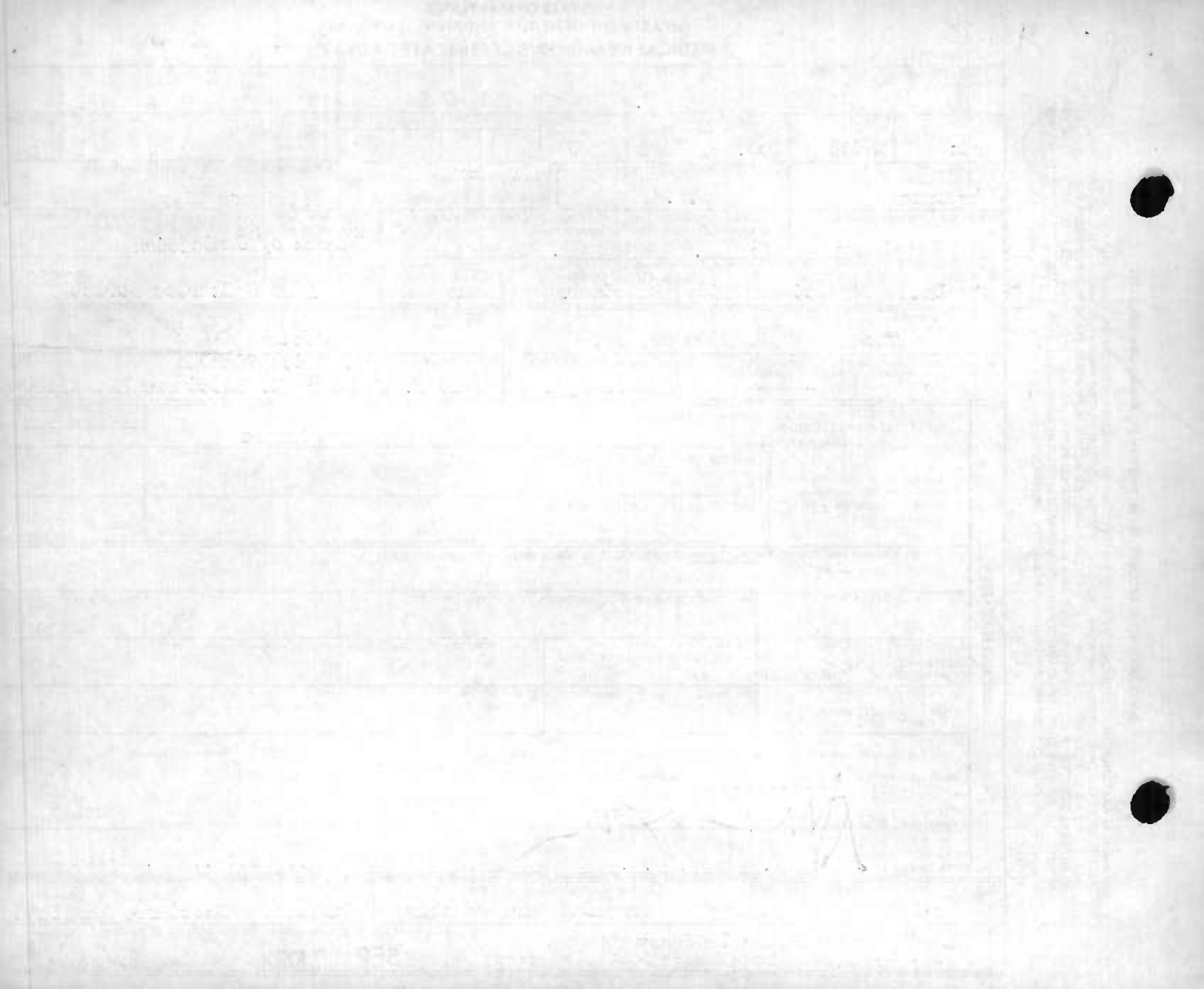
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Hunt, James Henry  
212241 Hunt, James Henry  
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Hunt, James Henry  
212241 Hunt, James Henry  
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                          |                                                                   |                                                                                                                                                             |                                                                               |                                                                                                                       |  |                                                                                                                     |                                              | REG. NO. 2 2 3 4 7 5 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------|----------------------------------------------|----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>THOMAS W. SIMMONS</b>                                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                          |                                                                   |                                                                                                                                                             |                                                                               | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH <b>9</b> DAY <b>4</b> YEAR <b>1982</b> |  | 2b. HOUR <b>M</b>                                                                                                   |                                              |                      |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH <b>Dec.</b> DAY <b>8</b> YEAR <b>1898</b>                                                                      | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>83</b> YRS.                 | IF UNDER 1 YR.<br>MONTHS <b>00</b> DAYS <b>00</b>                                                                                                           | IF UNDER 24 HRS.<br>HOURS <b>00</b> MIN. <b>00</b>                            | 2c. DATE PRONOUNCED DEAD<br>MONTH <b>9</b> DAY <b>4</b> YEAR <b>1982</b>                                              |  | 2d. HOUR <b>9p</b> M                                                                                                |                                              |                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                           |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                            |                                                                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                              |  |                                                                                                                     |                                              |                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                          |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1326 S. Charles St.</b> |                                                                   |                                                                                                                                                             |                                                                               | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bureau of Sanitation</b>                          |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                   |                                              |                      |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |                         | 13b. CITY<br><b>Baltimore City</b>                                                                                                       |                                                                   | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                                                                               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                       |  | 13e. STREET ADDRESS<br><b>1326 S Charles Street</b> <b>21230</b>                                                    |                                              |                      |  |
| 14. FATHER'S NAME<br>FIRST <b>Thomas</b> MIDDLE <b>W. Simmons, Sr.</b> LAST <b>Thomas</b>                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                          |                                                                   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Unknown</b> MIDDLE <b>Unknown</b> LAST <b>Unknown</b>                                                                  |                                                                               |                                                                                                                       |  |                                                                                                                     |                                              |                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                     |                         | (IF YES, GIVE WAR OR DATES)<br><b>-----</b>                                                                                              |                                                                   | 16b. SOCIAL SECURITY NO.<br><b>214-05-3462</b>                                                                                                              |                                                                               | 17. INFORMANT <b>Mrs. Edith Simmons</b><br><b>1326 S. Charles St. Baltimore, MD. 21230</b>                            |  |                                                                                                                     |                                              |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                              |                         |                                                                                                                                          |                                                                   |                                                                                                                                                             |                                                                               |                                                                                                                       |  |                                                                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                          |                                                                   |                                                                                                                                                             |                                                                               |                                                                                                                       |  |                                                                                                                     |                                              |                      |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                 |                                                                                                                                                             |                                                                               |                                                                                                                       |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |                                              |                      |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                          | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b> |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                                                                                                       |  |                                                                                                                     |                                              |                      |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                          | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)       |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |                                                                                                                       |  |                                                                                                                     |                                              |                      |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |                                                                                                                                          |                                                                   |                                                                                                                                                             |                                                                               |                                                                                                                       |  |                                                                                                                     |                                              |                      |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                          |                                                                   |                                                                                                                                                             | TITLE (SPECIFY)<br><b>Assistant</b> M.D. MEDICAL EXAMINER                     |                                                                                                                       |  | DATE SIGNED <b>9-5-82</b>                                                                                           |                                              |                      |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                          |                                                                   |                                                                                                                                                             | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>                                |                                                                                                                       |  |                                                                                                                     |                                              |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                          | 23b. DATE<br><b>9-9-82</b>                                        |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cemetery</b>           |                                                                                                                       |  | 23d. LOCATION<br>CITY OR TOWN <b>Woodlawn</b> COUNTY <b>Baltimore</b> STATE <b>Maryland</b>                         |                                              |                      |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Loring Byers Funeral Directors Inc.</b> ADDRESS <b>8728 Liberty Road, Randallstown, Md. 21133</b>                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                          |                                                                   |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 7 1982</b>                            |                                                                                                                       |  | 25b. REGISTRAR'S SIGNATURE<br> |                                              |                      |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked off item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                  |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                              |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|----------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                |  | 2a. DATE OF DEATH                                                                                      |  | MONTH DAY YEAR                                                                                                                                           |  | 2b. HOUR                                                            |  | REG. NO.                                     |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                      |  | FIRST MIDDLE LAST                                                                                      |  | 2a. DATE OF DEATH                                                                                                                                        |  | MONTH DAY YEAR                                                      |  | 2b. HOUR                                     |  |
| BERTHA                                                                                                                                                                                                                                                                                                |  | SIMONET                                                                                                |  | 9 / 30 / 82                                                                                                                                              |  | 1 A M                                                               |  |                                              |  |
| 3. SEX                                                                                                                                                                                                                                                                                                |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                              |  |
| Female                                                                                                                                                                                                                                                                                                |  | White                                                                                                  |  | MONTH DAY YEAR                                                                                                                                           |  | 91 YRS.                                                             |  | MONTHS DAYS HOURS MIN.                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                              |  |
| France                                                                                                                                                                                                                                                                                                |  | U.S.A.                                                                                                 |  |                                                                                                                                                          |  | Baltimore City                                                      |  | MD.                                          |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                              |  |
| Baltimore                                                                                                                                                                                                                                                                                             |  | Bon Secours Hospital                                                                                   |  | Lady Maid-Companion                                                                                                                                      |  | ---                                                                 |  |                                              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                          |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS                          |  |
| Maryland                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  | Baltimore                                                                                                                                                |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1813 Wilkens Avenue 21223                    |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME                                                                               |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)                                                                                         |  | 16b. SOCIAL SECURITY NO.                                            |  | 17. INFORMANT ADDRESS                        |  |
| Gentle                                                                                                                                                                                                                                                                                                |  | Simonet                                                                                                |  | Marie                                                                                                                                                    |  | Noel                                                                |  | Henry P. Simonet 1813 Wilkens Avenue 21223   |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                 |  | IMMEDIATE CAUSE (a)                                                                                    |  | DUE TO, OR AS A CONSEQUENCE OF (b)                                                                                                                       |  | DUE TO, OR AS A CONSEQUENCE OF (c)                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 5990                                                                                                                                                                                                                                                                                                  |  | Urinary tract infection with septicemic shock                                                          |  |                                                                                                                                                          |  |                                                                     |  | days                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                      |  | Secum dehydration, Senile dementia, Collapsed fracture of thoracic spine                               |  |                                                                                                                                                          |  |                                                                     |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY?                                                                                                                                            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                                              |  |
|                                                                                                                                                                                                                                                                                                       |  |                                                                                                        |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                 |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                    |  | 21b. TIME OF INJURY                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                           |  |                                                                     |  |                                              |  |
|                                                                                                                                                                                                                                                                                                       |  | HOUR A.M. MONTH DAY YEAR                                                                               |  |                                                                                                                                                          |  |                                                                     |  |                                              |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY                                                                                   |  | 21f. LOCATION                                                                                                                                            |  |                                                                     |  |                                              |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                     |  | (AT HOME STREET, FACTORY OFFICE, FARM, ETC.)                                                           |  | STREET CITY OR TOWN COUNTY STATE                                                                                                                         |  |                                                                     |  |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-27-82 to 9-30-82, that (I) (we) last saw the deceased alive on 9-30-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE                                                                                         |  | DEGREE                                                                                                                                                   |  | 22c. DATE SIGNED                                                    |  |                                              |  |
|                                                                                                                                                                                                                                                                                                       |  | S. Sygini                                                                                              |  | MD                                                                                                                                                       |  | 9-30-82                                                             |  |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                 |  | 22e. ADDRESS                                                                                           |  | 22f. DATE REC'D. BY REGISTRAR                                                                                                                            |  | REGISTRAR'S SIGNATURE                                               |  |                                              |  |
| SUJETA SANSIRI MD                                                                                                                                                                                                                                                                                     |  | Bon Secours Hospital                                                                                   |  | OCT 1 - 1982                                                                                                                                             |  | John J. Connel                                                      |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                             |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION                                                       |  |                                              |  |
| Cremation                                                                                                                                                                                                                                                                                             |  | 10/1/82                                                                                                |  | Loudon Park                                                                                                                                              |  | Baltimore                                                           |  | Maryland                                     |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                  |  | 24a. NAME                                                                                              |  | 24b. ADDRESS                                                                                                                                             |  | 24c. CITY OR TOWN                                                   |  | 24d. STATE                                   |  |
| Hubbard Funeral Home, Inc.                                                                                                                                                                                                                                                                            |  | 4107 Wilkens Ave.                                                                                      |  | 21229                                                                                                                                                    |  | Baltimore                                                           |  | Maryland                                     |  |

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UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                             |                                                                                                                                              |                                                                                                                                                             |                                                                                                 |                                                                  |  |                                    |                                   |  |
|---------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------|--|------------------------------------|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>BG <i>Gloria Simpson</i>                             |                                                                                                                                              |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br>8 / 19 / 82                                                 |                                                                  |  | 2b. HOUR MIN<br>3:45 AM            |                                   |  |
| 3 SEX<br><i>Female</i>                                                                      | 4 RACE<br><i>Black</i>                                                                                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 / 19 / 82                                                                                                           | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br>60                                        |                                                                  |  | 7b. IF UNDER 1 YEAR<br>MONTHS DAYS |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>                                | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                                |                                                                  |  |                                    |                                   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>                                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Baltimore City Hospitals</i> |                                                                                                                                                             |                                                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  |                                    | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |                                                                                                                                              |                                                                                                                                                             |                                                                                                 |                                                                  |  |                                    |                                   |  |
| 13a. STATE<br><i>Maryland</i>                                                               | 13b. COUNTY<br><i>Baltimore</i>                                                                                                              | 13c. CITY OR TOWN<br><i>Baltimore</i>                                                                                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><i>7210 North Alter St.</i>               |  |                                    |                                   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Willie James Simpson</i>                        |                                                                                                                                              |                                                                                                                                                             | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Gloria Armstrong</i>                         |                                                                  |  |                                    |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                        |                                                                                                                                              |                                                                                                                                                             | 16b. SOCIAL SECURITY NO.                                                                        |                                                                  |  | 17 INFORMANT ADDRESS               |                                   |  |

|                                                                                                                                                                                                                                                                                                                                                  |  |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiorespiratory arrest</i><br>7650<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <i>Extreme prematurity</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

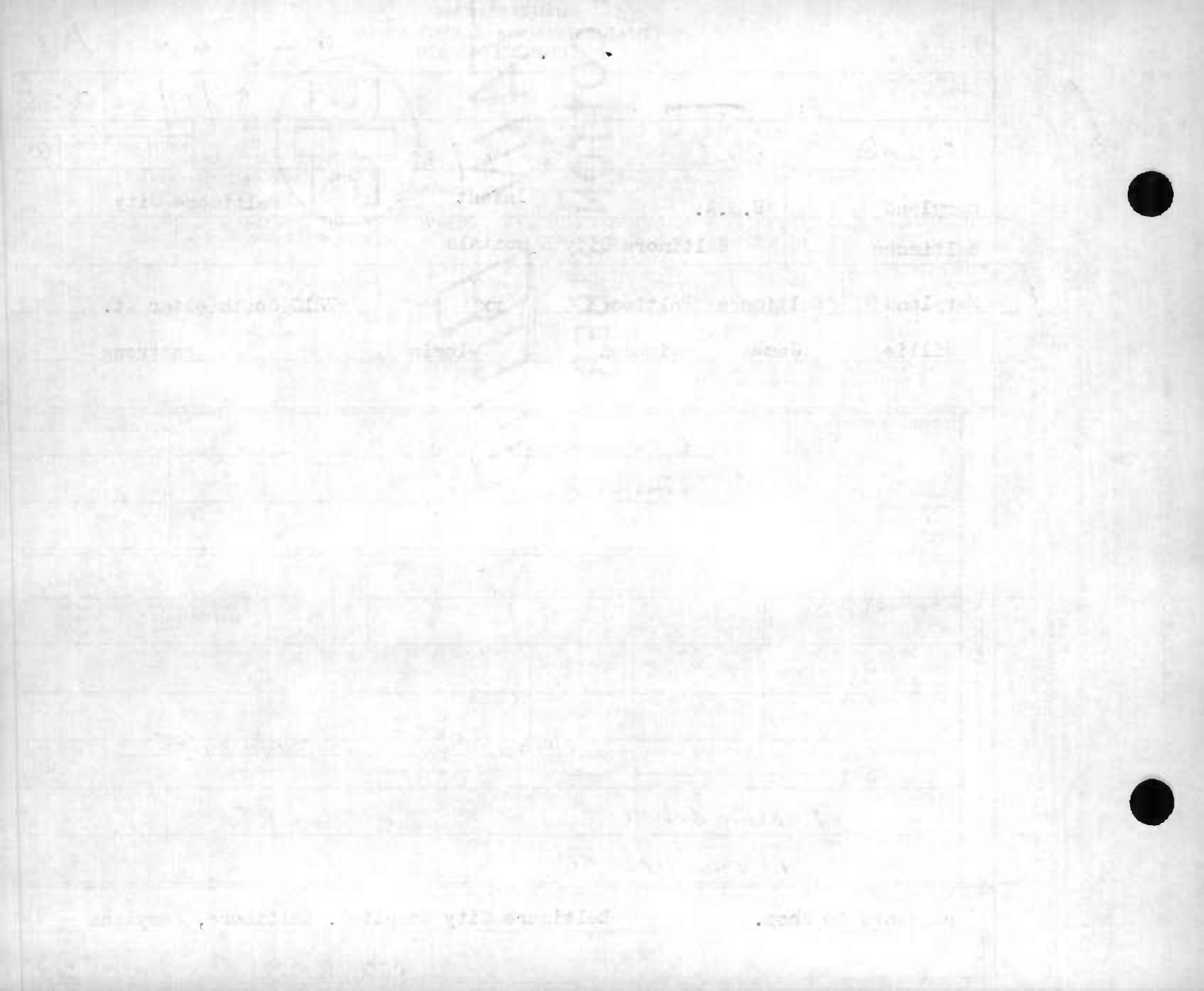
|                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                        |  |                                                                                                                                           |  |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                 |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                            |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                         |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/19/82 3:05 am</i> 19 <i>82</i> , to <i>8/19/82 3:45 am</i> 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>8/19/82</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                                                                           |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><i>R. Mulaikar MD</i>                                                                                                                                                                                                                                                                                                                                               |  |                                                                        |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED                                                                                                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>R. MULAIKAR MD</i>                                                                                                                                                                                                                                                                                                                        |  |                                                                        |  | 22e. ADDRESS                                                                                                                              |  |                                                                                                                            |  |

|                                                                       |  |           |  |                                                                                           |  |                                                    |  |
|-----------------------------------------------------------------------|--|-----------|--|-------------------------------------------------------------------------------------------|--|----------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>released to hosp.</i> |  | 23b. DATE |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Baltimore City Hospital, Baltimore, Maryland</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE         |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS                                  |  |           |  | 25a. DATE REC'D. BY REGISTRAR                                                             |  | 25b. REGISTRAR'S SIGNATURE<br><i>J. J. Carroll</i> |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                              |  |                                                                                                                                 |  | 8 2 2 3 4 7 8                                                                                                                                            |  |                                                                                                                                    |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                 |  | REG. NO.                                                                                                                                                 |  |                                                                                                                                    |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>BRUCE SIMPSON</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                 |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>SEPT. 27, 1982</b>                                                                                                   |  | 2b. HOUR <b>7<sup>00</sup> P<sup>M</sup></b>                                                                                       |  |
| 3. SEX <b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE <b>WHITE</b>                                                                                                            |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>03 02 1902</b>                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS                                                                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland.</b>                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                      |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.                                                                          |  |
| 10. CITY OR TOWN OF DEATH <b>Balto.</b>                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sales</b>                                                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Auto</b>                                                                                      |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13a. COUNTY <b>Baltimore</b>                                                                                                                                                                                                                                   |  | 13c. CITY OR TOWN <b>Baltimore</b>                                                                                              |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |  | 13e. STREET ADDRESS <b>5510 Dolores Ave. 21227</b>                                                                                 |  |
| 14. FATHER'S NAME FIRST <b>Andrew</b> MIDDLE <b>Bruce</b> LAST <b>Simpson</b>                                                                                                                                                                                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Elizabeth</b> MIDDLE <b>A.</b> LAST <b>Sullivan</b>                                           |  |                                                                                                                                                          |  |                                                                                                                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>                                                                                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO. <b>1942-1945</b>                                                                                       |  | 17. INFORMANT <b>Linda Simpson</b>                                                                                                                       |  | ADDRESS <b>5510 Dolores Ave 21227</b>                                                                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4360</b> IMMEDIATE CAUSE (a) <b>CEREBRO VASCULAR ACCIDENT</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.           |  |                                                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>                                                                                               |  |                                                                                                                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>                                                                                                                                                                                                 |  |                                                                                                                                 |  |                                                                                                                                                          |  |                                                                                                                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                           |  |                                                                                                                                    |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                             |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 24</b> , 19 <b>82</b> , to <b>Sept 27</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>Sept 27</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                 |  |                                                                                                                                                          |  |                                                                                                                                    |  |
| 22b. SIGNATURE <b>Halesh M. Patel M.D.</b> DEGREE                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                 |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED <b>Sept 27, 1982</b>                                                                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HALESH M. PATEL, M.D.</b>                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                 |  | 22e. ADDRESS <b>LUTHERAN HOSPITAL of MD. inc BALTIMORE, MD 21216</b>                                                                                     |  |                                                                                                                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                                           |  | 23b. DATE <b>9/30/82</b>                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>                                                                                         |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>                                                                  |  |
| 24. FUNERAL DIRECTOR NAME <b>Ambrose Funeral Home</b> ADDRESS <b>1328 Sulphur Spring Rd</b>                                                                                                                                                                                                                                                                                       |  |                                                                                                                                 |  | 25a. DATE REC'D. BY REGISTRAR <b>SEP 29 1982</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>                                                                                   |  |



RECEIVED IN DEPT. OF AGRICULTURE  
WASHINGTON, D.C.

BRUCE, Simpson  
White

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CERTIFICATE OF AGRICULTURAL AID

OFFICE OF AGRICULTURAL AID

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                           |                                                        |                                                                                                                                                             |                                                                                    |                                                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>William A Simpson</b>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                           | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09/23/82</b> |                                                                                                                                                             | 2b. HOUR<br><b>3:55P</b>                                                           |                                                                                                 |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br><b>White</b>                                                                                                                   |                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 16, 1930</b>                                                                                                  |                                                                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>52</b> YRS.                                               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                             |                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>John Hopkins Hospital</b> |                                                        |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b> |                                                                                                 |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                     |  | 13b. COUNTY<br><b>---</b>                                                                                                                 |                                                        | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                                                                                    | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Simpson</b>                                                                                                                                                                                                                                                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Helen Eagan</b>                                                                       |                                                        |                                                                                                                                                             |                                                                                    |                                                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>                                                                                                                                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>1951-1953</b>                                                               |                                                        | 17. INFORMANT<br>ADDRESS<br><b>Tanya Litvinuck 2219 Exxes St. 21231</b>                                                                                     |                                                                                    |                                                                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4148</b> IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Cardiogenic shock</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>70 minutes</b><br><b>90 minutes</b><br><b>32 hours</b> |  |                                                                                                                                           |                                                        |                                                                                                                                                             |                                                                                    |                                                                                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Atherosclerotic cardiovascular disease</b>                                                                                                                                                                                                                                             |  |                                                                                                                                           |                                                        |                                                                                                                                                             |                                                                                    |                                                                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                          |                                                        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                                                                                    |                                                                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                |                                                        | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |                                                                                    |                                                                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                    |                                                        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                    |                                                                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/22</b> , 19 <b>82</b> , to <b>9/23</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>9/23</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                |  |                                                                                                                                           |                                                        |                                                                                                                                                             |                                                                                    |                                                                                                 |
| 22b. SIGNATURE<br><b>Anthony Elias</b>                                                                                                                                                                                                                                                                                                                                                                                            |  | DEGREE<br><b>MD</b>                                                                                                                       |                                                        | 22c. DATE SIGNED<br><b>9/23/82</b>                                                                                                                          |                                                                                    |                                                                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ANTHONY ELIAS</b>                                                                                                                                                                                                                                                                                                                                                                     |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>                                                                                             |                                                        |                                                                                                                                                             |                                                                                    |                                                                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br><b>Sept. 27'82</b>                                                                                                           |                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>                                                                                              |                                                                                    |                                                                                                 |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                                                                                                                                                                                                                                                                                                                                                           |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Lilly &amp; Zeiler, Inc. 1901 Eastern Ave. 21231</b>                                           |                                                        |                                                                                                                                                             |                                                                                    |                                                                                                 |
| 25a. DATE RECD. BY REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                      |  | 25b. REGISTRAR'S SIGNATURE<br><b>SEP 28 1982</b>                                                                                          |                                                        |                                                                                                                                                             |                                                                                    |                                                                                                 |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and the medical examination must be completed.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                          |  | 8 2 2 3 4 8 0                                                       |  | REG. NO.                                                       |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|----------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  | 2a. DATE OF DEATH                                                                                                                                        |  | MONTH DAY YEAR                                                      |  | 2b. HOUR                                                       |  |
| Jack Sims                                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  | 9 19 82                                                                                                                                                  |  |                                                                     |  | M                                                              |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                 |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR                                             |  |
| Male                                                                                                                                                                                                                                                                                                                   |  | Black                                                                                                  |  | 8 MONTH DAY YRS. 12 14 8                                                                                                                                 |  | 70 YRS.                                                             |  | MONTHS DAYS HOURS MIN.                                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                                                |  |
| Virginia                                                                                                                                                                                                                                                                                                               |  | USA                                                                                                    |  |                                                                                                                                                          |  | Baltimore City MD                                                   |  |                                                                |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Baltimore                                                                                                                                                                                                                                                                                                              |  | 1239 E. Lanvale Street                                                                                 |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  | 13b. COUNTY                                                                                                                                              |  | 13c. CITY OR TOWN                                                   |  | 13d. INSIDE CITY LIMITS?                                       |  |
| Maryland                                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  | Baltimore                                                                                                                                                |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS                                            |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  | 15. MOTHER'S MAIDEN NAME                                                                                                                                 |  |                                                                     |  |                                                                |  |
| Jack Sims                                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  | =                                                                                                                                                        |  |                                                                     |  |                                                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                                                                                                                                                                                                                          |  |                                                                                                        |  | 16b. SOCIAL SECURITY NO.                                                                                                                                 |  | 17. INFORMANT ADDRESS                                               |  |                                                                |  |
| No                                                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  | 214-26-6226                                                                                                                                              |  | Susie Sims 1239 E. Lanvale St.                                      |  |                                                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1539 Metastatic Colon Carcinoma                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Oct. 1978         |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)                                                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  |                                                                                                                                                          |  | 20a. AUTOPSY?                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|                                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                          |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                     |  | 21b. TIME OF INJURY                                                                                    |  | 21c. HOW INJURY OCCURRED                                                                                                                                 |  |                                                                     |  |                                                                |  |
|                                                                                                                                                                                                                                                                                                                        |  | HOUR A.M. MONTH DAY YEAR P.M. 19                                                                       |  | ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2                                                                                                      |  |                                                                     |  |                                                                |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY                                                                                   |  | 21f. LOCATION                                                                                                                                            |  |                                                                     |  |                                                                |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                      |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                         |  | STREET CITY OR TOWN COUNTY STATE                                                                                                                         |  |                                                                     |  |                                                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July 12 19 82, to Sept 19 19 82, that (I) (we) last saw the deceased alive on Aug 9 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                                                |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  | DEGREE                                                                                                                                                   |  |                                                                     |  | 22c. DATE SIGNED                                               |  |
| James C. Wade                                                                                                                                                                                                                                                                                                          |  |                                                                                                        |  | M.D.                                                                                                                                                     |  |                                                                     |  | 9/20/82                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                  |  |                                                                                                        |  | 22e. ADDRESS                                                                                                                                             |  |                                                                     |  |                                                                |  |
| JAMES C. WADE M.D.                                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  | Johns Hopkins Hospital                                                                                                                                   |  |                                                                     |  |                                                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                              |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION                                                       |  | 23e. STATE                                                     |  |
| BURIAL                                                                                                                                                                                                                                                                                                                 |  | 9/25/82                                                                                                |  | Baltimore Cem                                                                                                                                            |  | Baltimore                                                           |  | Md.                                                            |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  | 25a. DATE                                                                                                                                                |  | 25b. BY REGISTRAR'S SIGNATURE                                       |  |                                                                |  |
| Wm. C. march F/H 1101 E. north Avenue                                                                                                                                                                                                                                                                                  |  |                                                                                                        |  | SEP 23 1982                                                                                                                                              |  | John G. Smith                                                       |  |                                                                |  |

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James C. ...

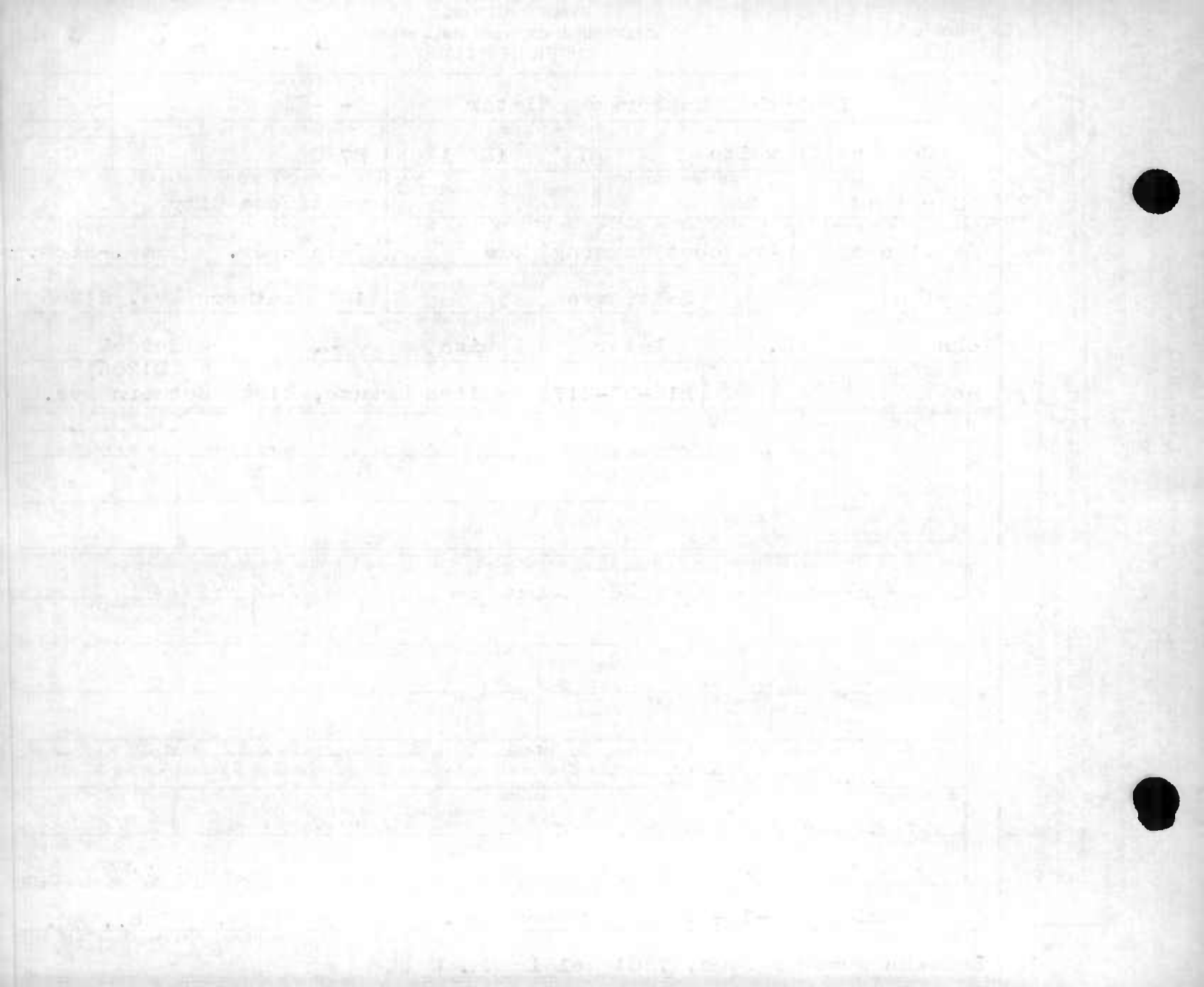
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                    |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                |  |                                                                                                 |  | 8 2 2 3 4 8 1                                                                                                                 |  |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                |  |                                                                                                 |  | REG. NO.                                                                                                                      |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Elizabeth Catherine Slater                                                                                                                                                                                                                                                                       |  |                                                                                                                                    |  |                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9-8-82                                  |  |                                                                                                 |  | 2b. HOUR<br>7 P. M.                                                                                                           |  |  |  |
| 3. SEX<br>female                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br>white                                                                                                                   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 18 1895                                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                  |  | IF UNDER 24 HRS.<br>HOURS MIN.                                                                                                |  |  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |  |                                                                                                 |  |                                                                                                                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Armocost Nursing Home |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Tele oper. |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Atl.-Rich. Co.                                             |  |                                                                                                                               |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                                                                  |  |                                                                                                                                    |  | 13b. COUNTY                                                                                                                                                 |  | 13c. CITY OR TOWN<br>Baltimore                                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>4107 Southern Ave. 21206                                                                               |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John H. Slater                                                                                                                                                                                                                                                                                |  |                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Louisa M. Seidel                                                                                           |  |                                                                                |  |                                                                                                 |  |                                                                                                                               |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no                                                                                                                                                                                                                                                              |  |                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-05-2170                                                                                      |  | 17. INFORMANT<br>ADDRESS (21206)<br>Pauline Krause, 4104 Southern Ave.         |  |                                                                                                 |  |                                                                                                                               |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Arteriosclerotic CVDisease, post stroke</i><br>4292 DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                      |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                |  |                                                                                                 |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>3 yrs                                                                      |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>Chronic urinary tract infection &amp; urinary lithiasis</i>                                                                                                                                   |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                |  |                                                                                                 |  |                                                                                                                               |  |  |  |
| 9a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                                                |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                |  |                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |                                                                                                 |  |                                                                                                                               |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                            |  |                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |                                                                                                 |  |                                                                                                                               |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 1980</i> , to <i>Sept 8 1982</i> , that (I) (we) last saw the deceased alive on <i>Sept 8 1982</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                |  |                                                                                                 |  |                                                                                                                               |  |  |  |
| 22b. SIGNATURE<br><i>Fredrick J. Vollmer, MD</i>                                                                                                                                                                                                                                                                                        |  |                                                                                                                                    |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |                                                                                |  | 22c. DATE SIGNED<br>9-10-82                                                                     |  |                                                                                                                               |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>FREDERICK J. VOLLMER MD                                                                                                                                                                                                                                                                        |  |                                                                                                                                    |  | 22e. ADDRESS<br>6100 YORK RD BALTIMORE MD 21212                                                                                                             |  |                                                                                |  |                                                                                                 |  |                                                                                                                               |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br>9-13-82                                                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cem.                                                                                                         |  |                                                                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Parkville, Balto., Md.                            |  |                                                                                                                               |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Lassahn Funeral Home, 7401 Belair Rd.                                                                                                                                                                                                                                                                   |  |                                                                                                                                    |  |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 20 1982                                   |  |                                                                                                 |  |                                                                                                                               |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>John J. Smith</i>                                                                                                                                                                                                                                                                                      |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                |  |                                                                                                 |  |                                                                                                                               |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                             |  |                                                                                                                                             |                                                                                                                                                      |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                        |                                                                                                                                       |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                             | REG. NO. 8 2 2 3 4 8 2                                                                                                                               |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                        |                                                                                                                                       |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>HENRY ALBERT SLITZER                                                                                                                                                                                                                                                                                         |  |                                                                                                                                             | 2a. DATE OF DEATH<br>9 18 82                                                                                                                         |                                                                                                                                                             |                                                                                                 | 2b. HOUR<br>10:55P <sup>M</sup>                                                      |                                                                        |                                                                                                                                       |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br>White                                                                                                                            |                                                                                                                                                      | 5. DATE OF BIRTH<br>7 4 14                                                                                                                                  |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.                                           |                                                                        | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States                                                                                               |                                                                                                                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |                                                                        |                                                                                                                                       |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VAMC 3900 Loch Raven Blvd Balto., |                                                                                                                                                      |                                                                                                                                                             |                                                                                                 | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Md. Guard           |                                                                        | 12b. KIND OF BUSINESS OR INDUSTRY<br>Security                                                                                         |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE Maryland                                                                                                                                                                                                                                   |  |                                                                                                                                             | 13b. CITY OR TOWN<br>Baltimore                                                                                                                       |                                                                                                                                                             | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                      | 13d. STREET ADDRESS<br>527 S. Lakewood Ave.                            |                                                                                                                                       |  |
| 14. FATHER'S NAME<br>FIRST Louis MIDDLE - LAST Slitzer                                                                                                                                                                                                                                                                                           |  |                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST Christina MIDDLE - LAST Boehm                                                                                      |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                        |                                                                                                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)<br>Yes NO OR UNKNOWN                                                                                                                                                                                                                                                    |  |                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br>W.W. II 212 05 8054                                                                                                      |                                                                                                                                                             | 17. INFORMANT<br>Patricia Levie                                                                 |                                                                                      | ADDRESS<br>526 S. Belnord Ave.                                         |                                                                                                                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Infection - probable</u><br><u>1890</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Renal cell Carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>with metastasis</u>                                 |  |                                                                                                                                             |                                                                                                                                                      |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>prior to admission</u><br><u>Dx 6/25/82</u><br><u>prior to admission</u>           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>0</u>                                                                                                                                                                                                        |  |                                                                                                                                             |                                                                                                                                                      |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                        |                                                                                                                                       |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                     |                                                                                                                                                             |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                            |  |                                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                           |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                      |                                                                        |                                                                                                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                     |  |                                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                               |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                      |                                                                        |                                                                                                                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE 21, 1982</u> to <u>SEPTEMBER 18, 1982</u> , that (I) (we) last saw the deceased alive on <u>SEPTEMBER 18, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. |  |                                                                                                                                             |                                                                                                                                                      |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                        |                                                                                                                                       |  |
| 22b. SIGNATURE<br><u>Steven G. Gevas MD</u>                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                             | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                                                                             |                                                                                                 | 22c. DATE SIGNED<br><u>9/19/82</u>                                                   |                                                                        |                                                                                                                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>STEVEN G. GEVAS</u>                                                                                                                                                                                                                                                                                  |  |                                                                                                                                             | 22e. ADDRESS<br>3900 Loch Raven Blvd. Balto., Md. 21218                                                                                              |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                        |                                                                                                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                              |  |                                                                                                                                             | 23b. DATE<br>Sept. 21, 1982                                                                                                                          |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery                                       |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>- - Ann Arundel Co., Md. |                                                                                                                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Lilly & Zeiler Inc. 1901 Eastern Ave.                                                                                                                                                                                                                                                                            |  |                                                                                                                                             |                                                                                                                                                      |                                                                                                                                                             | 25a. DATE RECEIVED BY REGISTRAR<br>SEP 23 1982                                                  |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Connel</u>                    |                                                                                                                                       |  |

Yes W. II Strictly Private 250 E. Blinn Ave.

Louis - - - - - Christiana - - - - - Bond

Harvard - - - - - Baltimore X 250 E. Lakewood Ave.

Ma. vland United States

X

Security Guard

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WHEN THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  | REG. NO. 8 2 2 3 4 8 3                                                                                                                                                                                                                                                                                                                 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  | 20. DATE KNOWN OF DEATH                                                                                                                                                                                                                                                                                                                |  |
| 1. DECEASED NAME (TYPE OR PRINT) JULIE Ann SMALL                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  | 20. DATE KNOWN OF DEATH MONTH DAY YEAR 9-6-82 19                                                                                                                                                                                                                                                                                       |  |
| 2. SEX female                                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  | 21. DATE PRONOUNCED DEAD MONTH DAY YEAR 9-6-82 19                                                                                                                                                                                                                                                                                      |  |
| 3. RACE white                                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  | 22. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.                                                                                                                                                                                                                                                                               |  |
| 4. DATE OF BIRTH MONTH DAY YEAR 5-27-67                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  | 23. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student                                                                                                                                                                                                                                                                   |  |
| 5. AGE (IN YEARS LAST BIRTHDAY) 15 YRS.                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  | 24. KIND OF BUSINESS OR INDUSTRY School                                                                                                                                                                                                                                                                                                |  |
| 6. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.                                                                                                                                                                                                                                                                                               |  |  |  |  |  |  |  |  |  | 25. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. CITY OR TOWN Harford 13c. INSIDE CITY LIMITS? YES [X] NO [ ] 13d. STREET ADDRESS 601 Beards Hill Rd. 21001                                                                                                          |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.J.                                                                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  | 14. FATHER'S NAME FIRST MIDDLE LAST Stewart A. Carpenter                                                                                                                                                                                                                                                                               |  |
| 8. CITIZEN OF WHAT COUNTRY? USA                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Viola Small                                                                                                                                                                                                                                                                            |  |
| 9. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]                                                                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no (IF YES, GIVE WAR OR DATES)                                                                                                                                                                                                                                       |  |
| 10. CITY OR TOWN OF DEATH Baltimore                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |  | 17. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                |  |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) S.T.U. University Hospital                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  | 18. INFORMANT ADDRESS Ruth V. Carr Aberdeen, Md.                                                                                                                                                                                                                                                                                       |  |
| 12. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. CITY OR TOWN Harford 13c. INSIDE CITY LIMITS? YES [X] NO [ ] 13d. STREET ADDRESS 601 Beards Hill Rd. 21001                                                                                                          |  |  |  |  |  |  |  |  |  | 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: 8147 Multiple injuries<br>IMMEDIATE CAUSE (a) } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) } DUE TO, OR AS A CONSEQUENCE OF<br>(c) } |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Stewart A. Carpenter                                                                                                                                                                                                                                                                               |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                                                           |  |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Viola Small                                                                                                                                                                                                                                                                            |  |  |  |  |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                        |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no (IF YES, GIVE WAR OR DATES)                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                        |  |
| 17. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                        |  |
| 18. INFORMANT ADDRESS Ruth V. Carr Aberdeen, Md.                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                        |  |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: 8147 Multiple injuries<br>IMMEDIATE CAUSE (a) } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) } DUE TO, OR AS A CONSEQUENCE OF<br>(c) } |  |  |  |  |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                        |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                                                                                                                                                                                                      |  |
| 19c. AUTOPSY? YES [ ] NO [X]                                                                                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                        |  |
| 20a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH                                                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  | 20b. TIME OF INJURY HOUR AM MONTH DAY YEAR 10:32PM 9-3-82 19                                                                                                                                                                                                                                                                           |  |
| 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) pedestrian struck by a pick-up truck                                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                        |  |
| 21a. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]                                                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street                                                                                                                                                                                                                                                                     |  |
| 21c. LOCATION STREET CITY OR TOWN COUNTY STATE 600blk. Beardshill Rd. Harford Co., Maryland                                                                                                                                                                                                                                            |  |  |  |  |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                        |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy [ ] Inspection [X] Inquiry [ ] and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ].                                                                                          |  |  |  |  |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                        |  |
| 22b. ACTUAL SIGNATURE Margaret A. Korell, M.D. Assistant                                                                                                                                                                                                                                                                               |  |  |  |  |  |  |  |  |  | DATE SIGNED 9-7-82                                                                                                                                                                                                                                                                                                                     |  |
| 22c. EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street                                                                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  |                                                                                                                                                                                                                                                                                                                                        |  |
| 23a. BURIAL, CREMATION, REMOVAL Burial                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  | 23b. DATE 9-12-82                                                                                                                                                                                                                                                                                                                      |  |
| 23c. NAME OF CEMETERY OR CREMATORY New Bridge Bapt.                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Rising Sun Cecil Md.                                                                                                                                                                                                                                                                           |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS North East, Md.                                                                                                                                                                                                                                                                                      |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 14 1982                                                                                                                                                                                                                                                                   |  |

RECEIVED  
JAN 10 1961  
U.S. AIR FORCE

RECEIVED  
JAN 10 1961

NOV 10 1960



10-10-60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                         |  |                                                                                                                         |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 8 2 2 3 4 8 4                                                                                                                            |  | REG. NO.                                                                                                                                                    |  |                                                                                         |  |                                                                                                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Albert A Smith</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                          |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>09 09 82</b>                                                                                                         |  | 2b. HOUR<br><b>9:30 P.M.</b>                                                            |  |                                                                                                                         |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br><b>White</b>                                                                                                                  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>March, 1, 1904</b>                                                                                                    |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.                                       |  | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS. HOURS MIN.                                                |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                               |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                       |  |                                                                                                                         |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Balto. Gen. Hosp.</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Stationary</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Engineer</b>                                                                    |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                    |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                |  | 13e. STREET ADDRESS<br><b>600, Light St. Apt. 320, Balto. Md.</b>                       |  |                                                                                                                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>William S. Smith</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Florence Galeona</b>                                                                                       |  |                                                                                         |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br><b>215-03-3382</b>                                                                                           |  | 17. INFORMANT<br><b>Mrs. Mildred E. Smith, Same as above</b>                                                                                                |  |                                                                                         |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH Enter only one cause per item (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary edema + congestion</b><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive heart failure with cardiomegaly + hypertrophy of</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } <b>Coarctation at atherosclerosis, severe</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Lft Ventricle</b> |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Nephroarteriosclerosis - Liver metastatic disease.</b>                                                                                                                                                                                                                                                                                                |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                         |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |  |                                                                                                                                                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                            |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>                                                                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                         |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)                                                                       |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                         |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>09/08/82</b> 19 <b>82</b> , to <b>09/09/82</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>09/09/82</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (I) (did) (did not) view the body after death.                                                                                                                 |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                         |  |                                                                                                                         |  |
| 22b. SIGNATURE<br><b>S. L. Soler M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                          |  | DEGREE<br><b>M.D.</b>                                                                                                                                       |  |                                                                                         |  | 22c. DATE SIGNED<br><b>09/09/82</b>                                                                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. L. Soler</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                          |  | 22e. ADDRESS<br><b>3001 S Hanover St., Balt. MD.</b>                                                                                                        |  |                                                                                         |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 23b. DATE<br><b>Sept. 13, 1982</b>                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Park</b>                                                                                           |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Glen Burnie, A.A. Co. Maryland</b>        |  |                                                                                                                         |  |
| 24. FUNERAL DIRECTOR NAME<br><b>McClully Funeral Home, 130 E. Fort Ave. Balto. Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 15 1982</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Cough</b>                                      |  |                                                                                                                         |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

2008 BP  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  |                                                                                                                                       |                                                                                    |                                                                                                                                                             |                                                                                  |                                                                                                 |                                                                                     |                                                                              |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Harry R. Smith, Sr.                                                                                                                                                                                                                                                                                                                                                                               |                  |                                                                                                                                       | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 9 24 1982 |                                                                                                                                                             |                                                                                  | 2b. HOUR<br>M 12:15 P.M.                                                                        |                                                                                     |                                                                              |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                           | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>01 20 05                                                                                        | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>77 YRS.                                    | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                                                                                                    | 7c. DATE PRONOUNCED DEAD<br>9 27 1982                                            | 2d. HOUR<br>P.M.                                                                                |                                                                                     |                                                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                    |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                |                                                                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD                                      |                                                                                     |                                                                              |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4233 Old Frederick Road |                                                                                    |                                                                                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Grain Inspector |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>City of Baltimore                              |                                                                              |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                   |                  | 13b. COUNTY<br>---                                                                                                                    |                                                                                    | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |                                                                                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                     | 13e. STREET ADDRESS<br>Chamber of Commerce<br>4233 Old Frederick Road, 21229 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown                                                                                                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Bessie Russell                    |                                                                                                                                                             |                                                                                  |                                                                                                 |                                                                                     |                                                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                              |                  |                                                                                                                                       | 16b. SOCIAL SECURITY NO.<br>220-09-9867                                            |                                                                                                                                                             | 17. INFORMANT<br>Elizabeth Marciano 806 W. 33rd St. 21211                        |                                                                                                 |                                                                                     |                                                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>(c) _____                                                                                                                                  |                  |                                                                                                                                       |                                                                                    |                                                                                                                                                             |                                                                                  |                                                                                                 |                                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                 |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                       |                                                                                    |                                                                                                                                                             |                                                                                  |                                                                                                 |                                                                                     |                                                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                  |                                                                                                                                                             |                                                                                  |                                                                                                 | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                              |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                         |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)    |                                                                                                 |                                                                                     |                                                                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                           |                  |                                                                                                                                       | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                        |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                |                                                                                                 |                                                                                     |                                                                              |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |                                                                                                                                       |                                                                                    |                                                                                                                                                             |                                                                                  |                                                                                                 |                                                                                     |                                                                              |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>                                                                                                                                                                                                                                                                                                                                                                                               |                  |                                                                                                                                       | TITLE (SPECIFY)<br>M.D. Assistant                                                  |                                                                                                                                                             |                                                                                  |                                                                                                 | DATE SIGNED<br>9-27-82                                                              |                                                                              |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Dennis F. Smyth, M.D.                                                                                                                                                                                                                                                                                                                                                                              |                  |                                                                                                                                       | ADDRESS<br>111 Penn Street                                                         |                                                                                                                                                             |                                                                                  |                                                                                                 |                                                                                     |                                                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                   |                  | 23b. DATE<br>09-29-82                                                                                                                 |                                                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Park                                                                                                         |                                                                                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Woodlawn Baltimore Md.                            |                                                                                     |                                                                              |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.                                                                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                       |                                                                                    | 25a. DATE REC'D. BY REGISTRAR<br>SEP 29 1982                                                                                                                |                                                                                  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Connel</i>                                             |                                                                                     |                                                                              |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                |  |                                                                                                                                        |  | REG. NO. 8 2 2 3 4 8 6                                                                                                                                      |  |                                                                                                                                                      |  |                                                                                                                         |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>HELEN MARIE SMITH</b>                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                        |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Sept. 26, 1982</b>                                                                                                   |  |                                                                                                                                                      |  | 2b. HOUR<br><b>5:45 AM</b>                                                                                              |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br><b>White</b>                                                                                                                |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Nov. 17, 1901</b>                                                                                                     |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>80</b>                                                                                                    |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                             |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                                                    |  |                                                                                                                         |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Edgewood Nursing Home</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>                                                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                                                                    |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                       |  | 13b. COUNTY                                                                                                                            |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                         |  |                                                                                                                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>A. Kriewald</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Unknown</b>                                                                                                |  |                                                                                                                                                      |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.<br><b>217 07 4613</b>                                                                                         |  | 17. INFORMANT<br><b>William C. Smith,</b>                                                                                                                   |  |                                                                                                                                                      |  | ADDRESS<br><b>Same</b>                                                                                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4029</b> IMMEDIATE CAUSE (a) <b>HYPERTENSIVE CVD DISEASE, Post STROKE</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2+ yrs</b>                                                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>DEPRESSIVE STATE</b>                                                                                                                                                                                                                     |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |  |                                                                                                                                                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                    |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                                                                                      |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                           |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                                                      |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-27, 1982</b> , to <b>9-26, 1982</b> , that (I) (we) lost saw the deceased alive on <b>9-1, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                              |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                                                                         |  |
| 22b. SIGNATURE<br><b>Frederick J. Vollmer, M.D.</b>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                        |  |                                                                                                                                                             |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>9-27-82</b>                                                                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Frederick J. Vollmer, M. D.</b>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                        |  | 22e. ADDRESS<br><b>6100 York Road, Balto., MD 21212</b>                                                                                                     |  |                                                                                                                                                      |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br><b>9/29/82</b>                                                                                                            |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>                                                                                                    |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Balto., MD</b>                                                                                         |  |                                                                                                                         |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>Henry W. Jenkins &amp; Sons Co.<br/>4905 York Road Balto., MD 21212</b>                                                                                                                                                                                                                                                                     |  |                                                                                                                                        |  |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 28 1982</b>                                                                                                  |  |                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                        |  |                                                                                                                                                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>Joan J. Connel</b>                                                                                                  |  |                                                                                                                         |  |

London, 1994

101

1950 York Road, Baltimore, MD 21212

W. J. Jenkins & Co.

Dr. Friedrich J. Volkmann, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/76  
(VR A 15 (4))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                     |  |                                                                                                                                                                |                                                         |                                                                                              |  |                                                                        |                            | 8 2 2 3 4 8 7                                                                                                           |  |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|----------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------------------------------------------------------------------|--|--|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                     |  |                                                                                                                                                                |                                                         |                                                                                              |  |                                                                        |                            | REG. NO.                                                                                                                |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>SMITH HERBERT</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                     |  |                                                                                                                                                                | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>09 / 10 / 82</b> |                                                                                              |  |                                                                        | 2b. HOUR<br><b>7:00 AM</b> |                                                                                                                         |  |  |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br><b>BLACK</b>                                                                                                             |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>9 8 24</b>                                                                                                               |                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS.                                            |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                         |                            | IF UNDER 24 HRS.<br>HOURS MIN.                                                                                          |  |  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                       |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |                                                         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD.                                 |  |                                                                        |                            |                                                                                                                         |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PROVIDENT HOSPITAL</b> |  |                                                                                                                                                                |                                                         | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                                      |                            |                                                                                                                         |  |  |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                     |  |                                                                                                                                                                |                                                         |                                                                                              |  |                                                                        |                            |                                                                                                                         |  |  |  |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 13b. COUNTY                                                                                                                         |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                          |                                                         | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2800 Ulman Avenue</b>                        |                            |                                                                                                                         |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Travis Smith</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Emliy Waters</b>                                                                                              |                                                         |                                                                                              |  |                                                                        |                            |                                                                                                                         |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.<br><b>226-20-9531</b>                                                                                                                 |                                                         | 17. INFORMANT ADDRESS<br><b>Deborah Johnson 1101 Penn. Ave #204</b>                          |  |                                                                        |                            |                                                                                                                         |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br><b>1629 IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Carcinoma of the Lung with massive Hemoptysis year</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 mins</b> |  |                                                                                                                                     |  |                                                                                                                                                                |                                                         |                                                                                              |  |                                                                        |                            |                                                                                                                         |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                     |  |                                                                                                                                                                |                                                         |                                                                                              |  |                                                                        |                            |                                                                                                                         |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                               |                                                         |                                                                                              |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                     |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                        |                                                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |                                                                        |                            |                                                                                                                         |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                            |                                                         | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                               |  |                                                                        |                            |                                                                                                                         |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9-7</b> , 19 <b>82</b> , to <b>9/10</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>9/9/</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                  |  |                                                                                                                                     |  |                                                                                                                                                                |                                                         |                                                                                              |  |                                                                        |                            |                                                                                                                         |  |  |  |
| 22b. SIGNATURE<br><b>E. Okeke</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                     |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                         |                                                                                              |  | 22c. DATE SIGNED<br><b>9/10/82</b>                                     |                            |                                                                                                                         |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>EMELIA OKEKE</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                     |  | 22e. ADDRESS<br><b>2600 LIBERTY HEIGHTS AVE, BALT</b>                                                                                                          |                                                         |                                                                                              |  |                                                                        |                            |                                                                                                                         |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br><b>9/16/82</b>                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. Nat. Cem.</b>                                                                                                  |                                                         | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Balto. MD</b>                                  |  |                                                                        |                            |                                                                                                                         |  |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                     |  |                                                                                                                                                                |                                                         | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>SEP 15 1982 John J. Smith</b> |  |                                                                        |                            |                                                                                                                         |  |  |  |

MEDICAL CERTIFICATION

1512 BP

MADE IN U.S.A.

1980

1980

EXHIBIT 1014-94-1-4

EXHIBIT 1014-94-1-4



Handwritten signature and date: 2012/1/30

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE JUDICIAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                      |         |                                                                                                            |                                                                |                                                                                                                                                             |                                                                               |                                                                                              |  |                                                                                     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                  |         |                                                                                                            | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED                      |                                                                                                                                                             |                                                                               | 2b. HOUR                                                                                     |  |                                                                                     |
| James W. Smith                                                                                                                                                                                                                                                                                                                                                                                                                                       |         |                                                                                                            | 9 3 1982                                                       |                                                                                                                                                             |                                                                               | M                                                                                            |  |                                                                                     |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                               | 4. RACE | 5. DATE OF BIRTH<br>(MONTH DAY YEAR)                                                                       | 6. AGE (IN YEARS<br>LAST BIRTHDAY)                             | IF UNDER 1 YR.<br>MONTHS DAYS                                                                                                                               | IF UNDER 24 HRS.<br>HOURS MIN.                                                | 2c. DATE<br>PRONOUNCED<br>DEAD                                                               |  | 2d. HOUR                                                                            |
| M                                                                                                                                                                                                                                                                                                                                                                                                                                                    | NEGRO   | 12-23-91                                                                                                   | 61 YRS.                                                        |                                                                                                                                                             |                                                                               | 9 5 1982                                                                                     |  | 3:25 P. M.                                                                          |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                         |         | 7b. CITIZEN OF WHAT COUNTRY?                                                                               |                                                                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                         |  |                                                                                     |
| Md                                                                                                                                                                                                                                                                                                                                                                                                                                                   |         | U.S.A.                                                                                                     |                                                                |                                                                                                                                                             |                                                                               | Baltimore City, MD.                                                                          |  |                                                                                     |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                            |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                |                                                                                                                                                             |                                                                               | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                             |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                                |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                            |         | 1521 N. Broadway                                                                                           |                                                                |                                                                                                                                                             |                                                                               |                                                                                              |  |                                                                                     |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                           |         | 13b. COUNTY                                                                                                |                                                                | 13c. CITY OR TOWN                                                                                                                                           |                                                                               | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                                                                     |
| Md                                                                                                                                                                                                                                                                                                                                                                                                                                                   |         |                                                                                                            |                                                                | BALTO.                                                                                                                                                      |                                                                               | 13e. STREET ADDRESS<br>1251 N. Broadway                                                      |  |                                                                                     |
| 14. FATHER'S NAME<br>Richard Smith                                                                                                                                                                                                                                                                                                                                                                                                                   |         |                                                                                                            |                                                                | 15. MOTHER'S MAIDEN NAME<br>Mamie Dells                                                                                                                     |                                                                               |                                                                                              |  |                                                                                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                |         |                                                                                                            |                                                                | 16b. SOCIAL SECURITY NO.                                                                                                                                    |                                                                               | 17. INFORMANT ADDRESS                                                                        |  |                                                                                     |
| No                                                                                                                                                                                                                                                                                                                                                                                                                                                   |         |                                                                                                            |                                                                | 215-18-7586                                                                                                                                                 |                                                                               | Annatell Hawkins 2727 E. Preston                                                             |  |                                                                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u><br>4029<br>Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u><br><u>lying cause lost.</u><br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF               |         |                                                                                                            |                                                                |                                                                                                                                                             |                                                                               |                                                                                              |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                                  |         |                                                                                                            |                                                                |                                                                                                                                                             |                                                                               |                                                                                              |  |                                                                                     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                               |         |                                                                                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?              |                                                                                                                                                             |                                                                               |                                                                                              |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                            |         |                                                                                                            | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19     |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                                                                              |  |                                                                                     |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                            |         |                                                                                                            | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |                                                                                              |  |                                                                                     |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |                                                                                                            |                                                                |                                                                                                                                                             |                                                                               |                                                                                              |  |                                                                                     |
| ACTUAL<br>SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                  |         |                                                                                                            | Dennis F. Smyth, M.D.                                          |                                                                                                                                                             |                                                                               | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER                                                |  | DATE<br>SIGNED 9-6-82                                                               |
| EXAMINER'S NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                   |         |                                                                                                            | Dennis F. Smyth, M.D.                                          |                                                                                                                                                             |                                                                               | ADDRESS<br>111 Penn Street                                                                   |  |                                                                                     |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                         |         | 23b. DATE                                                                                                  |                                                                | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |                                                                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                   |  |                                                                                     |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                               |         | 9/10/82                                                                                                    |                                                                | Mt. Calvary Cem                                                                                                                                             |                                                                               | A.D. County Md                                                                               |  |                                                                                     |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                                                                                                         |         |                                                                                                            | ADDRESS                                                        |                                                                                                                                                             |                                                                               | 25a. DATE REC'D. BY REGISTRAR                                                                |  |                                                                                     |
| Lock's FUNERAL Home                                                                                                                                                                                                                                                                                                                                                                                                                                  |         |                                                                                                            | 1304 N Central Ave                                             |                                                                                                                                                             |                                                                               | SEP 10 1982                                                                                  |  |                                                                                     |





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 4 8 9

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                |                                                                                                                                                            |                                                                           |                                                                                               |                                                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JO ANN SMITH</b>                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                |                                                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 27 1982</b>           |                                                                                               | 2b. HOUR<br><b>6:50pm</b>                                                                                                  |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                        | 4 RACE<br><b>Black</b>                                                                                                                         | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 13 48</b>                                                                                                       |                                                                           | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>34 YRS.</b>                                              | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                               | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                     | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                           | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                              |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |                                                                                                                                                            |                                                                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                              |                                                                                                                            |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                |                                                                                                                                                            | 13b. COUNTY<br><b>Baltimore</b>                                           | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                         | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Herman Eppes</b>                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                |                                                                                                                                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mae Fowlkes Eppes</b> |                                                                                               |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Unknown</b>                                                                                                                                                                                                                                                                                            |                                                                                                                                                |                                                                                                                                                            | 16b. SOCIAL SECURITY NO.<br><b>219-50-6160</b>                            |                                                                                               |                                                                                                                            |
| 17. INFORMANT<br><b>Joyce Henson</b>                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                |                                                                                                                                                            | ADDRESS<br><b>1600 Freedom Way North 21213</b>                            |                                                                                               |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>respiratory arrest</b><br><b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>pulmonary metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>breast cancer</b> |                                                                                                                                                |                                                                                                                                                            |                                                                           |                                                                                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 minutes</b><br><b>1 year</b><br><b>2 years</b>                        |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>None</b>                                                                                                                                                                                                                                                                   |                                                                                                                                                |                                                                                                                                                            |                                                                           |                                                                                               |                                                                                                                            |
| 19a. DATE OF OPERATION<br><b>9/27</b>                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>breast cancer</b>                                                                                   |                                                                           | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                       |                                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                          |                                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>None</b> |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                  |                                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>None</b>                                                                      |                                                                           | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>None</b>                              |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/25</b> 19 <b>82</b> to <b>9/27</b> 19 <b>82</b> , that (we) last saw the deceased alive on <b>9/27</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If yes, did (did not) view the body after death.)                                                         |                                                                                                                                                |                                                                                                                                                            |                                                                           |                                                                                               |                                                                                                                            |
| 22b. SIGNATURE<br><b>R Lange</b>                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                | DEGREE<br><b>MD</b>                                                                                                                                        |                                                                           | 22c. DATE SIGNED<br><b>9/27/82</b>                                                            |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R LANGE</b>                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                | 22e. ADDRESS<br><b>Johns Hopkins Hosp</b>                                                                                                                  |                                                                           |                                                                                               |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPEIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                | 23b. DATE<br><b>10/2/82</b>                                                                                                                                |                                                                           | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>                                  |                                                                                                                            |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Avenue</b>                                                                       |                                                                           |                                                                                               |                                                                                                                            |
| 25a. DATE REC'D. BY REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                |                                                                                                                                                            |                                                                           | REGISTRAR'S SIGNATURE<br><b>John J. Ganiel</b>                                                |                                                                                                                            |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. It may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. It should be detached for use as the burial-transit permit. Thereafter, remove carbon copies, pages 2 and 3, and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner's name must be typed in item 21.

1962-1963

1962-1963

THE STATE OF NEW YORK

1962-1963

1962-1963



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed with your records after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                        |  | 8 2 2 3 4 9 0                                                                                                                                               |  |                                                                                                                            |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                        |  | REG. NO.                                                                                                                                                    |  |                                                                                                                            |                                              |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Joseph C SMITH                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                        |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>September 27, 1982                                                                                                   |  | 2b. HOUR<br>10:46 PM                                                                                                       |                                              |
| 3. SEX<br>male                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br>Black                                                                                                                       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 12 92                                                                                                               |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90 YRS.                                                                                 |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                    |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                 |                                              |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                              |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                  |  |                                                                                                                                        |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  | 13e. STREET ADDRESS<br>1027 Cathedral St. Apt. 13K                                                                         |                                              |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                   |  | 13b. COUNTY                                                                                                                            |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |  |                                                                                                                            |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William H. Smith                                                                                                                                                                                                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary                                                                                  |  |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                                                                                                                                                                                                                                                   |  | 16b. SOCIAL SECURITY NO.<br>228-05-3690                                                                                                |  | 17. INFORMANT<br>ADDRESS<br>Nina Smith 1027 Cathedral St. Apt. 13K                                                                                          |  |                                                                                                                            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Caudal respiratory arrest</u><br>4275<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                      |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>80</u> , to <u>Sept</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>Sept</u> 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.               |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 22b. SIGNATURE<br><u>Kendall R Faulkner MD</u>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                        |  | DEGREE<br>ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/><br>PHYSICIAN DIRECTOR PHYSICIAN     |  | 22c. DATE SIGNED<br>9/28/82                                                                                                |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Kendall Faulkner, M.D.                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                        |  | 22e. ADDRESS<br>300 Armory Pl, Suite 3C<br>c/o Maryland General Hospital                                                                                    |  |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                   |  | 23b. DATE<br>10/1/82                                                                                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Zion Cem.                                                                                                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                                                                |                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Avenue                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                        |  | 25. DATE RECEIVED BY REGISTRAR<br>OCT 1 1982                                                                                                                |  |                                                                                                                            |                                              |

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

|      |                    |      |
|------|--------------------|------|
| 1917 | September 27, 1917 | 1917 |
|      |                    |      |
|      |                    |      |

Washington, D. C.  
Maryland General Hospital

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 21st inst. regarding the matter of the

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

X

Very respectfully,  
J. G. [Signature]

J. G. [Signature]  
Chief, Maryland General Hospital

1917

2778 BP  
DHMH-16 30M 2/80  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                   |  |                                                                                                                                           |  | 8 2 2 3 4 9 1<br>REG. NO.                                                                                                                                   |  |                                                                                                                                                 |                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOSEPH HERBERT SMITH</b>                                                                                                                                                                                                                                                                                |  |                                                                                                                                           |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9-9-82</b>                                                                                                        |  | 2b. HOUR<br>MIN.<br><b>7<sup>50</sup> P<sup>M</sup></b>                                                                                         |                                                               |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br><b>WHITE</b>                                                                                                                   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1-8-1894</b>                                                                                                       |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b><br>YRS. MONTHS DAYS HOURS MIN.                                                                     |                                                               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                                               |                                                               |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>EDGEWOOD NURSING HOME</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MECHANIC</b>                                                                         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AUTOMOBILE</b>                                                                                          |                                                               |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                |  |                                                                                                                                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  |                                                                                                                                                 |                                                               |
| 13a. STATE<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY<br><b>BALTIMORE</b>                                                                                                           |  | 13c. STREET ADDRESS<br><b>919 EVESHAM AVE. 21212</b>                                                                                                        |  |                                                                                                                                                 |                                                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ROBERT AMOS SMITH</b>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                           |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELLA REESE</b>                                                                                          |  |                                                                                                                                                 |                                                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>                                                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW 1 212-09-4165</b>                                                        |  | 17. INFORMANT ADDRESS<br><b>21784<br/>ETHEL H. CABLE 6704 RIDGE RD. ELDERSBURG, MD.</b>                                                                     |  |                                                                                                                                                 |                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4292 Arteriosclerotic C-V Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.    |  |                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5+ yrs</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b>Urinary tract infection, recurrent</b>                                                                                                                                                                                      |  |                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                                                                                 |                                                               |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                          |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                      |                                                               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                                                 |                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                           |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                                                 |                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-29</b> , 19 <b>80</b> , to <b>9-9</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>9-9</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                                                                                 |                                                               |
| 22b. SIGNATURE<br><b>Frederick J. Vollmer, MD.</b><br>DEGREE                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                           |  | 22c. DATE SIGNED<br><b>9-10-82</b>                                                                                                                          |  | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                               |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>FREDERICK J. VOLLMER MD</b>                                                                                                                                                                                                                                                                                                |  |                                                                                                                                           |  | 22f. ADDRESS<br><b>6100 YORK RD, BALTIMORE, MD 21212</b>                                                                                                    |  |                                                                                                                                                 |                                                               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b>                                                                                                                                                                                                                                                                                                       |  | 23b. DATE<br><b>SEPT. 13, 1982</b>                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GREENMOUNT CREMATORY</b>                                                                                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD.</b>                                                                              |                                                               |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>MITCHELL WIEDEFELD HOME 6500 YORK RD. 21212</b>                                                                                                                                                                                                                                                                             |  |                                                                                                                                           |  | 24a. DATE REC'D. BY REGISTRAR<br><b>SEP 15 1982</b>                                                                                                         |  |                                                                                                                                                 |                                                               |
|                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                           |  | 24b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                                                                                         |  |                                                                                                                                                 |                                                               |

MEDICAL CERTIFICATION



97-1-1-1

March 1944

88-1-1-1

NOTICE  
TO  
THE  
PUBLIC



200

11/11/44

11/11/44



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                            |  |                                                                                                        |  | REG. NO. 8 2 2 3 4 9 2                                                                                                                                   |  |                                                                |                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                          |  |                                                                                                        |  | 1 DECEASED NAME (TYPE OR PRINT)                                                                                                                          |  |                                                                |                                              |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR                                                                                                                |  |                                                                |                                              |
| Leroy Smith                                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  | 9 18 82 7 <sup>15</sup> / <sub>4</sub> M                                                                                                                 |  |                                                                |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                                          |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |                                              |
| male                                                                                                                                                                                                                                                                                                            |  | Black                                                                                                  |  | 9 4 07                                                                                                                                                   |  | 75 YRS.                                                        |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                |                                              |
| Maryland                                                                                                                                                                                                                                                                                                        |  | USA                                                                                                    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                                     |  |                                                                |                                              |
| Baltimore                                                                                                                                                                                                                                                                                                       |  | John L. Deaton Med. Cent.                                                                              |  | Baltimore City MD.                                                                                                                                       |  |                                                                |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |                                              |
| Baltimore                                                                                                                                                                                                                                                                                                       |  | John L. Deaton Med. Cent.                                                                              |  |                                                                                                                                                          |  |                                                                |                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                                      |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS?                                       |                                              |
| Maryland                                                                                                                                                                                                                                                                                                        |  | Baltimore                                                                                              |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                      |  | 13e. STREET ADDRESS                                            |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                             |  | 108 N. Sticker Street                                                                                                                                    |  |                                                                |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.                                                                               |  | 17. INFORMANT ADDRESS                                                                                                                                    |  |                                                                |                                              |
| Yes                                                                                                                                                                                                                                                                                                             |  | N/A                                                                                                    |  | Bessie Thompson 1024 Popular Grove St                                                                                                                    |  |                                                                |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) 4360 Pneumonia, Gram Negative                                                                                                                                                                                                                                                               |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |                                              |
| DUE TO, OR AS A CONSEQUENCE OF (b) SALTINE CPAS.                                                                                                                                                                                                                                                                |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |                                              |
| DUE TO, OR AS A CONSEQUENCE OF (c) St. Chelberts seizure                                                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                            |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY?                                                                                                                                            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                              |
|                                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                 |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                |                                              |
|                                                                                                                                                                                                                                                                                                                 |  | P.M. 19                                                                                                |  |                                                                                                                                                          |  |                                                                |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                |                                              |
|                                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-24, 1982, to 9-18, 1982, that (I) (we) last saw the deceased alive on 9-18, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                  |  |                                                                                                        |  | DEGREE                                                                                                                                                   |  | 22c. DATE SIGNED                                               |                                              |
| MARSHALL J. BROWN                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 9-18-82                                                        |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                           |  |                                                                                                        |  | 22e. ADDRESS                                                                                                                                             |  |                                                                |                                              |
| MARSHALL J. BROWN                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  | 611 S. CHARLES ST. 21230                                                                                                                                 |  |                                                                |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                       |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |                                              |
| BURIAL                                                                                                                                                                                                                                                                                                          |  | 9/24/                                                                                                  |  | Balto. Nat. Cem                                                                                                                                          |  | Baltimore Md.                                                  |                                              |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                       |  |                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR (b) REGISTRAR'S SIGNATURE                                                                                                  |  |                                                                |                                              |
| Wm. C. March F/H 1101 E. north Avenue                                                                                                                                                                                                                                                                           |  |                                                                                                        |  | SEP 21 1982 John J. Canfield                                                                                                                             |  |                                                                |                                              |



Handwritten notes on lined paper, including a circular diagram and various illegible text fragments.

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

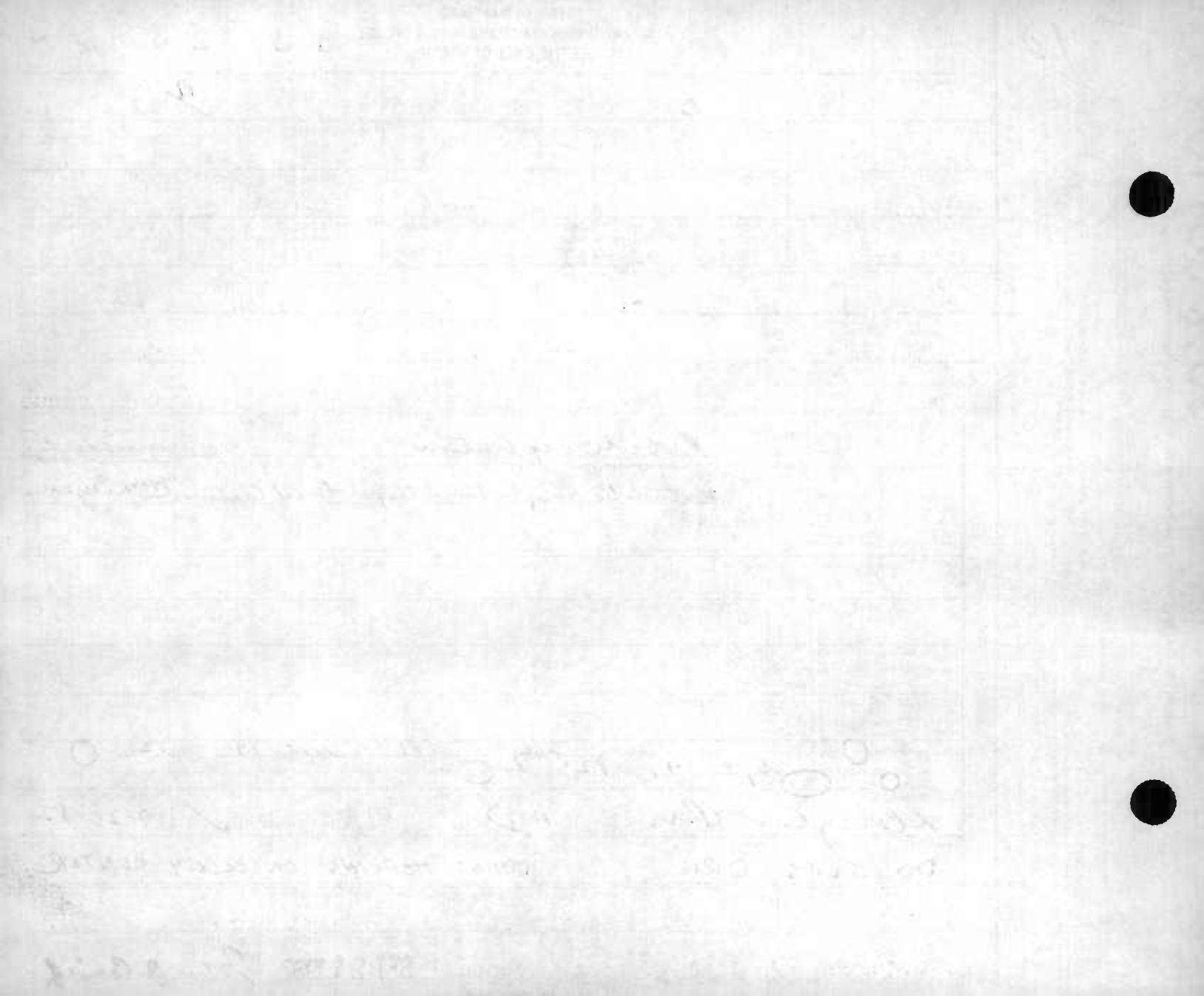
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1580

99

1201 BP

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                          |  |                                                                                                                                                                |  |                                                                                              |  |                                                                                                                         |  | 8 2 2 3 4 9 3<br>REG. NO.         |  |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                    |  | I. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Marvin C. Smith</b>                                                          |  |                                                                                                                                                                |  |                                                                                              |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>9 20 82</b>                                                                      |  | 2b. HOUR<br><b>M</b>              |  |  |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><b>Black</b>                                                                                                                  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11 3 51</b>                                                                                                              |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>30 YRS.</b>                                            |  | IF UNDER 1 YEAR MONTHS DAYS                                                                                             |  | IF UNDER 24 HRS. HOURS MIN.       |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                               |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                           |  |                                                                                                                         |  |                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |  |                                                                                                                                                                |  |                                                                                              |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY                                                                                                                              |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                          |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>4025 Greenmount Avenue</b>                                                                    |  |                                   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>William T. Smith Sr.</b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Louise Meade</b>                                                                                              |  |                                                                                              |  |                                                                                                                         |  |                                   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>                                                                                                   |  | 17. INFORMANT ADDRESS<br><b>Venessa Smith 4025 Greenmount Avenue</b>                                                                                           |  |                                                                                              |  |                                                                                                                         |  |                                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Probable aspiration</b><br><b>1580</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Metastatic Anaplastic Retroperitoneal Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>immediate</b><br><b>3 years</b> |  |                                                                                                                                          |  |                                                                                                                                                                |  |                                                                                              |  |                                                                                                                         |  |                                   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>1580</b>                                                                                                                                                                                                                                                               |  |                                                                                                                                          |  |                                                                                                                                                                |  |                                                                                              |  |                                                                                                                         |  |                                   |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |  |                                                                                                                                                                |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                                 |  |                                                                                              |  |                                                                                                                         |  |                                   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> WORK                                                                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                      |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                 |  |                                                                                              |  |                                                                                                                         |  |                                   |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>July</b> , 19 <b>81</b> , to <b>Sept. 19</b> , 19 <b>82</b> , that (1) (we) lost saw the deceased alive on <b>Sept. 14</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.                                 |  |                                                                                                                                          |  |                                                                                                                                                                |  |                                                                                              |  |                                                                                                                         |  |                                   |  |  |  |
| 22b. SIGNATURE<br><b>Douglas Orr</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                          |  | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                                                                                              |  | 22c. DATE SIGNED<br><b>9-20-82</b>                                                                                      |  |                                   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DOUGLAS ORR</b>                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                          |  | 22e. ADDRESS<br><b>JOHNS HOPKINS ONCOLOGY CENTER</b>                                                                                                           |  |                                                                                              |  |                                                                                                                         |  |                                   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br><b>9/25/82</b>                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>                                                                                                   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore MD.</b>                              |  |                                                                                                                         |  |                                   |  |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>Wm. C. March F/h 1101 E. north Avenue</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                          |  |                                                                                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 21 1982</b>                                          |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Carver</b>                                                                    |  |                                   |  |  |  |



item 8 #G571 9/29/82 ph

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 2 3 4 9 4  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                   |                                                                                                                                 |                                                                                                 |                                                                                                                                       |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MAUDE P SMITH                                                                                                                                                                                                                                                                                                      |  |                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9-8-82                          |                                                                                                                                                             |                                                                                   | 2b. HOUR<br>1205 AM                                                                                                             |                                                                                                 |                                                                                                                                       |  |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br>NEGRO                                                                                                            |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1-26-1895                                                                                                             |                                                                                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS                                                                                       |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N. CAROLINA                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                         |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                                                      |                                                                                                 |                                                                                                                                       |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE, MD                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAL HOSPITAL |                                                                        |                                                                                                                                                             |                                                                                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED                                                     |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                     |  |
| 13a. STATE<br>MD.                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                             | 13b. COUNTY<br>BNA                                                     |                                                                                                                                                             | 13c. CITY OR TOWN<br>BALTIMORE                                                    |                                                                                                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                       |  |
| 13e. STREET ADDRESS<br>304 BELMONT TOWERS                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                             | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Caswell Phillips       |                                                                                                                                                             |                                                                                   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lizzie                                                                         |                                                                                                 |                                                                                                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                |  |                                                                                                                             | 16b. SOCIAL SECURITY NO.<br>578-22-0932                                |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br>Edith E. Coleman 1642 Moreland Ave                    |                                                                                                                                 |                                                                                                 |                                                                                                                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1991 METASTATIC CANCER ? lymphoepithelioma<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                   |                                                                                                                                 |                                                                                                 |                                                                                                                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                        |  |                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                   |                                                                                                                                 |                                                                                                 |                                                                                                                                       |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                            |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                  |  |                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                                 |                                                                                                 |                                                                                                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                              |  |                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |                                                                                                                                 |                                                                                                 |                                                                                                                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-17 19 82, to 9-8 19 82, that (I) (we) last saw the deceased alive on 9-7 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death)                                                         |  |                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                   |                                                                                                                                 |                                                                                                 |                                                                                                                                       |  |
| 22b. SIGNATURE<br>Jeffrey M. Moll                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                             | DEGREE<br>M.D.                                                         |                                                                                                                                                             |                                                                                   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br>9-8-82                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JEFFREY M. MOLL, M.D.                                                                                                                                                                                                                                                                                            |  |                                                                                                                             | 22e. ADDRESS<br>SINAL HOSPITAL                                         |                                                                                                                                                             |                                                                                   |                                                                                                                                 |                                                                                                 |                                                                                                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                    |  |                                                                                                                             | 23b. DATE<br>9/14/82                                                   |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Lincoln Mem Cem Washington D.C.             |                                                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                      |                                                                                                                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave                                                                                                                                                                                                                                                                                        |  |                                                                                                                             | ADDRESS<br>SEP 10 1982                                                 |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR                                                     |                                                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br>John J. Givich                                                    |                                                                                                                                       |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATHUnit No. 138630  
82 23495  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                 |                                                                          |                                                                                                                                                             |                                                              |                                                                                                                                                        |                                                                                                 |                                                                                                                            |                                                |                                              |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>SARAH SMITH</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                 | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 28 82</b>                    |                                                                                                                                                             | 2b. HOUR<br>P. M.<br><b>5:30 P.</b>                          |                                                                                                                                                        |                                                                                                 |                                                                                                                            |                                                |                                              |  |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br><b>N</b>                                                                                                             |                                                                          | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 16 20</b>                                                                                                       |                                                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b>                                                                                                           |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>                                                                              |                                                | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>MD.</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>South Car</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>                                                                                     |                                                                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b>                                                                                               |                                                                                                 |                                                                                                                            |                                                |                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hosp.</b> |                                                                          |                                                                                                                                                             |                                                              | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Rosewood State Hosp.</b>                                                        |                                                                                                 |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY              |                                              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                 | 13b. COUNTY<br><b>Balto</b>                                              |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Balto</b>                            |                                                                                                                                                        | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS<br><b>3915 Grantly Rd.</b> |                                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Moses</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Amelia Jefferson</b> |                                                                                                                                                             |                                                              |                                                                                                                                                        |                                                                                                 |                                                                                                                            |                                                |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                 | 16b. SOCIAL SECURITY NO.<br><b>215-18-9193</b>                           |                                                                                                                                                             | 17. INFORMANT<br><b>James Smith</b>                          |                                                                                                                                                        |                                                                                                 | ADDRESS<br><b>3915 Grantly Rd.</b>                                                                                         |                                                |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive Cerebro Vascular Accident</b><br><b>3484</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Intra cerebral Bleed</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Bilateral Uncal Herniation &amp; Respir. Arrest!</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost    |  |                                                                                                                                 |                                                                          |                                                                                                                                                             |                                                              |                                                                                                                                                        |                                                                                                 |                                                                                                                            |                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                 |                                                                          |                                                                                                                                                             |                                                              |                                                                                                                                                        |                                                                                                 |                                                                                                                            |                                                |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                         |                                                                                                                                                             |                                                              | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br><b>BRAIN</b>                                                   |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>        |                                                                                                                                                             |                                                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                          |                                                                                                 |                                                                                                                            |                                                |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                 | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                                                                                                                                                             |                                                              | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                      |                                                                                                 |                                                                                                                            |                                                |                                              |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>9-24-82</b> , 19____, to <b>9-28-82</b> , 19____, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>9-28-82</b> , 19____, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did not view the body after death. |  |                                                                                                                                 |                                                                          |                                                                                                                                                             |                                                              |                                                                                                                                                        |                                                                                                 |                                                                                                                            |                                                |                                              |  |
| 22b. SIGNATURE<br><b>Dogub</b><br><b>9061</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                 |                                                                          |                                                                                                                                                             |                                                              | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 |                                                                                                                            | 22c. DATE SIGNED<br><b>9-28-82</b>             |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D. S. PATEL</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                 |                                                                          |                                                                                                                                                             |                                                              | 22e. ADDRESS<br><b>SINAI HOSPITAL</b>                                                                                                                  |                                                                                                 |                                                                                                                            |                                                |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                 | 23b. DATE<br><b>10/14/82</b>                                             |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crownville Vet.</b> |                                                                                                                                                        |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto Md.</b>                                                             |                                                |                                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leroy A. Dyett</b>                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                 |                                                                          |                                                                                                                                                             |                                                              | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 30 1982</b>                                                                                                    |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canish</b>                                                                        |                                                |                                              |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified also.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                               |                                       |                                                                                                                                               |                                                                                                                                                              | 8 2 2 3 4 9 6<br>REG. NO.                                                                                                                  |                                                            |                                                                                                                               |                                                 |                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|---------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Stella Mae Smith                                                                                                                                                                                                                                                            |                                       |                                                                                                                                               |                                                                                                                                                              | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>August 30, 1982                                                                                     |                                                            |                                                                                                                               |                                                 | 2b. HOUR<br>9:18 PM |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                   | 4. RACE<br>White                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 14, 1935                                                                                           |                                                                                                                                                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>46 YRS.                                                                                                 |                                                            | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |                                                 |                     |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                               | 9. CITIZEN OF WHAT COUNTRY?<br>U.S.A. |                                                                                                                                               | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD |                                                                                                                               |                                                 |                     |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                             |                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore General Hospital |                                                                                                                                                              | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                                                              |                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home                                                                                 |                                                 |                     |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD                                                                                                                                                                                                   |                                       | 13b. COUNTY<br>A.A.                                                                                                                           | 13c. CITY OR TOWN<br>Glen Burnie                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                            | 13e. STREET ADDRESS (Marley Park)<br>217 Highland Rd.      |                                                                                                                               |                                                 |                     |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Harry R. Wolfe                                                                                                                                                                                                                                                           |                                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Pauline M. Cole                                                                              |                                                                                                                                                              | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No N/A                                 |                                                            |                                                                                                                               |                                                 |                     |
| 16b. SOCIAL SECURITY NO.<br>214.30.1983                                                                                                                                                                                                                                                                            |                                       | 17. INFORMANT (Daughter) ADDRESS 775 Dogwood Tr.<br>Mrs. Mary K. Donachy-Crownsville, MD.                                                     |                                                                                                                                                              |                                                                                                                                            |                                                            |                                                                                                                               |                                                 |                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>4100 IMMEDIATE CAUSE (a) Cardio Respiratory Arrest.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Cardiogenic shock<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Massive Antero lateral myocardial Infarction   |                                       |                                                                                                                                               |                                                                                                                                                              |                                                                                                                                            |                                                            |                                                                                                                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18                                                                                                                                                                                |                                       |                                                                                                                                               |                                                                                                                                                              |                                                                                                                                            |                                                            |                                                                                                                               |                                                 |                     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                             |                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                              |                                                                                                                                                              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |                                                            | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                 |                     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                           |                                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                    |                                                                                                                                                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |                                                            |                                                                                                                               |                                                 |                     |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                       |                                       | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        |                                                                                                                                                              | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                            |                                                                                                                               |                                                 |                     |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-30, 19 82, to 8-30, 19 82, that (I) (we) lost<br>saw the deceased alive on 8-30, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death. |                                       |                                                                                                                                               |                                                                                                                                                              |                                                                                                                                            |                                                            |                                                                                                                               |                                                 |                     |
| 22b. SIGNATURE<br>Edwin E. Pagan MD                                                                                                                                                                                                                                                                                |                                       | DEGREE                                                                                                                                        |                                                                                                                                                              | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                            | 22c. DATE SIGNED<br>8-30-82                                                                                                   |                                                 |                     |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Edwin E. Pagan                                                                                                                                                                                                                                                            |                                       | 22e. ADDRESS<br>3001 South Hanover St Baltimore MD.                                                                                           |                                                                                                                                                              |                                                                                                                                            |                                                            |                                                                                                                               |                                                 |                     |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                             |                                       | 23b. DATE<br>3 Sept. 82                                                                                                                       |                                                                                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY<br>MD. Vet. Cemetery                                                                                    |                                                            | 23d. LOCATION<br>Crownsville, A.A., MD.                                                                                       |                                                 |                     |
| 24. FUNERAL DIRECTOR<br>NAME<br>Singleton Funeral Home                                                                                                                                                                                                                                                             |                                       | Glen Burnie MD.                                                                                                                               |                                                                                                                                                              | 25a. DATE REC'D. BY REGISTRAR<br>AUG 31 1982                                                                                               |                                                            | 25b. REGISTRAR'S SIGNATURE<br>John J. Carver                                                                                  |                                                 |                     |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and a medical investigation will be conducted.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 4 9 7  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                        |                                                                        |                                                                                                                                                              |  |                                                                                                 |  |                                                                                                                            |                                                                    |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Thelma Smith</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                        | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 10 82</b>                  |                                                                                                                                                              |  | 2b. HOUR<br><b>4 30 P M</b>                                                                     |  |                                                                                                                            |                                                                    |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br><b>Black</b>                                                                                                                |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 22 45</b>                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>36 YRS</b>                                                |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>36 YRS</b>                                                                         |                                                                    |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                          |  | 9. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                              |                                                                        | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                              |  |                                                                                                                            |                                                                    |  |
| 12. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                        |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b> |                                                                        |                                                                                                                                                              |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                 |  | 15. KIND OF BUSINESS OR INDUSTRY                                                                                           |                                                                    |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>16a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                         |  | 16b. COUNTY<br><b>Baltimore</b>                                                                                                        |                                                                        | 16c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                        |  | 16d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 16e. STREET ADDRESS<br><b>5117 Pembridge Avenue</b>                                                                        |                                                                    |  |
| 17. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lee Green</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                        |                                                                        | 18. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Pricisilla Vincent</b>                                                                                   |  |                                                                                                 |  |                                                                                                                            |                                                                    |  |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                        |                                                                        | 20. SOCIAL SECURITY NO.<br><b>218-44-8542</b>                                                                                                                |  | 21. INFORMANT<br>ADDRESS<br><b>Ronald Smith 5117 Pembridge Avenue</b>                           |  |                                                                                                                            |                                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio Respiratory Arrest</b><br><b>4151</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Probable Pulmonary embolism</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Probable Puerperal Sepsis</b><br>Approximate interval between onset and death: <b>36 hrs.</b>                |  |                                                                                                                                        |                                                                        |                                                                                                                                                              |  |                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |                                                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Hypertension, Diabetes</b>                                                                                                                                                                                                                                                |  |                                                                                                                                        |                                                                        |                                                                                                                                                              |  |                                                                                                 |  |                                                                                                                            |                                                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                              |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                             |  |                                                                                                                                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>9-9 19-82</b>    |                                                                                                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)                 |  |                                                                                                                            |                                                                    |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                   |  |                                                                                                                                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                              |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |  |                                                                                                                            |                                                                    |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>9-9 19-82</b> to <b>9-10 19-82</b> , that (1) <input checked="" type="checkbox"/> saw the deceased alive on <b>9-9-82</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (1) <input checked="" type="checkbox"/> did (did not) see the body after death. |  |                                                                                                                                        |                                                                        |                                                                                                                                                              |  |                                                                                                 |  |                                                                                                                            |                                                                    |  |
| 22b. SIGNATURE<br><b>L. Young Jr. M.D.</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                        | 22c. ADDRESS<br><b>2300 Capenon Blvd</b>                               |                                                                                                                                                              |  | 22d. DATE SIGNED<br><b>9-10-82</b>                                                              |  |                                                                                                                            |                                                                    |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>L. C. Young Jr.</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                        | 22f. ADDRESS<br><b>2300 Capenon Blvd</b>                               |                                                                                                                                                              |  |                                                                                                 |  |                                                                                                                            |                                                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                        | 23b. DATE<br><b>9/15/82</b>                                            |                                                                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Nat. Mem. Pk.</b>                                  |  |                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Avenue</b>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                        |                                                                        |                                                                                                                                                              |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 15 1982</b>                                             |  |                                                                                                                            |                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                        |                                                                        |                                                                                                                                                              |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                             |  |                                                                                                                            |                                                                    |  |

NOTES - 2001

W. J. L. L. L.

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to the city of New York  
for the purpose of  
conducting business

W. J. L. L. L.  
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W. J. L. L. L.

SEP 13 1985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                    |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                        |  |                                                                                                 |  | 8 2 2 3 4 9 8<br>REG. NO.                                                                                                  |                                   |                                                     |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Theodore B Smith, Jr.</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    |  |                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>05</b> YEAR <b>82</b>                               |  |                                                                                                                            |                                   | 2b. HOUR<br><b>9:35</b> P.M.                        |  |
| 3. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br><b>W</b>                                                                                                                |  | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>27</b> YEAR <b>11</b>                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.                                               |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                                                                             |                                   | IF UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b>       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NJ</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                         |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balt City</b> MD.                                    |  |                                                                                                                            |                                   |                                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balt</b>                                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St Agnes Hosp.</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Personnel Manager</b>    |  |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY |                                                     |  |
| 13a. STATE<br><b>md</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  | 13b. COUNTY<br><b>balt</b>                                                                                                         |  | 13c. CITY OR TOWN<br><b>Balt.</b>                                                                                                                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>302 G N. Chapel Gate</b>                                                                         |                                   |                                                     |  |
| 14. FATHER'S NAME<br>FIRST <b>Theodore</b> MIDDLE <b>B</b> LAST <b>Smith</b>                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Ella</b> MIDDLE <b>M.</b> LAST <b>Smith</b>                                                                            |  |                                                                                                 |  |                                                                                                                            |                                   |                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>UNK</b>                                                                                                                                                                                                                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.<br><b>080-70-257</b>                                                                                      |  | 17. INFORMANT<br><b>302 N. Chapel Gate Balto., Md.</b><br><b>Mrs. Kay K. Smith</b><br><b>#21229</b>                                                         |  |                                                                                                 |  |                                                                                                                            |                                   |                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4292</b><br>IMMEDIATE CAUSE (a) <b>Respiratory Distress Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>COPD</b> <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>Coronary Artery Disease COPD</b>                                                                                                                                                                                                                                              |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |                                   |                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |                                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)                                                                              |  |                                                                                                 |  |                                                                                                                            |                                   |                                                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                                              |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                            |                                   |                                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/26/82</b> 19 to <b>9/5/82</b> 19 that (I) (we) lost<br>saw the deceased alive on <b>9/5/82</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If I/we) (did) (did not) view the body after death.                                                                                  |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |                                   |                                                     |  |
| 22b. SIGNATURE<br><b>G. Hallick</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                    |  | DEGREE<br><b>MD</b>                                                                                                                                         |  |                                                                                                 |  | 22c. DATE SIGNED                                                                                                           |                                   |                                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>G. Hallick, M. D.</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                    |  | 22e. ADDRESS<br><b>St Agnes Hosp.</b>                                                                                                                       |  |                                                                                                 |  |                                                                                                                            |                                   |                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br><b>9-7-82</b>                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Pk. Cem.</b>                                                                                         |  |                                                                                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                                                            |                                   |                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>G. Truman Schwab</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                    |  | 3512 <b>Frederick</b> <b>Ave.</b><br>ADDRESS<br><b>#21229</b>                                                                                               |  |                                                                                                 |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 9 1982</b>                                                                         |                                   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b> |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 show any injury, or other traumatic event, the medical examiner must be notified and a report filed.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 4 9 9  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                           |        |                                                                                                                                                             |                   |                                                                     |       |                                                                |          |                                                 |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|---------------------------------------------------------------------|-------|----------------------------------------------------------------|----------|-------------------------------------------------|--|
| DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                          |  | FIRST                                                                                                     | MIDDLE | LAST                                                                                                                                                        | 2a. DATE OF DEATH |                                                                     | MONTH | DAY                                                            | YEAR     | 2b. HOUR                                        |  |
| WALTER PERRY SMITH                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                           |        |                                                                                                                                                             | 9                 |                                                                     | 4     | 82                                                             | 12:07 AM |                                                 |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE                                                                                                   |        | 5. DATE OF BIRTH                                                                                                                                            |                   | 6. AGE (IN YEARS (LAST BIRTHDAY))                                   |       | IF UNDER 1 YEAR                                                |          | IF UNDER 24 HRS.                                |  |
| MALE                                                                                                                                                                                                                                                                                                                                                                      |  | N                                                                                                         |        | MONTH DAY YEAR<br>11 15 21                                                                                                                                  |                   | 61 YRS.                                                             |       | MONTHS DAYS                                                    |          | HOURS MIN.                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                              |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |       |                                                                |          |                                                 |  |
| MD.                                                                                                                                                                                                                                                                                                                                                                       |  | U.S.A.                                                                                                    |        |                                                                                                                                                             |                   | BALTIMORE CITY MD.                                                  |       |                                                                |          |                                                 |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        |                                                                                                                                                             |                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |       | 12b. KIND OF BUSINESS OR INDUSTRY                              |          |                                                 |  |
| BALTIMORE                                                                                                                                                                                                                                                                                                                                                                 |  | JOUTH BALTIMORE GEN. HOSP.                                                                                |        |                                                                                                                                                             |                   | WHSE                                                                |       |                                                                |          |                                                 |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                              |  | 13b. COUNTY                                                                                               |        | 13c. CITY OR TOWN                                                                                                                                           |                   | 13d. INSIDE CITY LIMITS?                                            |       | 13e. STREET ADDRESS                                            |          |                                                 |  |
| MD                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                           |        | BALTIMORE                                                                                                                                                   |                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |       | 3608 FERNHILL AVE.                                             |          |                                                 |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME                                                                                  |        |                                                                                                                                                             |                   |                                                                     |       |                                                                |          |                                                 |  |
| FIRST MIDDLE LAST<br>PERRY SMITH                                                                                                                                                                                                                                                                                                                                          |  | FIRST MIDDLE LAST<br>LIZZIE CLAIRBORNE                                                                    |        |                                                                                                                                                             |                   |                                                                     |       |                                                                |          |                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES <input checked="" type="checkbox"/> IF UNKNOWN) (IF YES, GIVE WAR OR DATES)                                                                                                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.                                                                                  |        | 17. INFORMANT ADDRESS                                                                                                                                       |                   |                                                                     |       |                                                                |          |                                                 |  |
| Yes                                                                                                                                                                                                                                                                                                                                                                       |  | 214-14-2153                                                                                               |        | Walter Smith 4020 1/2 N Rogers Apt F                                                                                                                        |                   |                                                                     |       |                                                                |          |                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                  |  |                                                                                                           |        |                                                                                                                                                             |                   |                                                                     |       |                                                                |          | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                           |        |                                                                                                                                                             |                   |                                                                     |       |                                                                |          | 9/3/82                                          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                                                                            |  |                                                                                                           |        |                                                                                                                                                             |                   |                                                                     |       |                                                                |          | 7/24/82                                         |  |
| (b) <u>Emphysema</u>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                           |        |                                                                                                                                                             |                   |                                                                     |       |                                                                |          |                                                 |  |
| (c) <u>SQUAMOUS CELL Carcinoma Esophagus</u>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                           |        |                                                                                                                                                             |                   |                                                                     |       |                                                                |          | 5/82                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                        |  |                                                                                                           |        |                                                                                                                                                             |                   |                                                                     |       |                                                                |          |                                                 |  |
| NONE                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                           |        |                                                                                                                                                             |                   |                                                                     |       |                                                                |          |                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |        |                                                                                                                                                             |                   | 20a. AUTOPSY?                                                       |       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |          |                                                 |  |
| 7/13/82                                                                                                                                                                                                                                                                                                                                                                   |  | SQUAMOUS CELL CA - ESOPHAGUS                                                                              |        |                                                                                                                                                             |                   | YES <input type="checkbox"/> NO <input type="checkbox"/>            |       | YES <input type="checkbox"/> NO <input type="checkbox"/>       |          |                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                   |                                                                     |       |                                                                |          |                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                   |                                                                     |       |                                                                |          |                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 10</u> , 19 <u>82</u> , to <u>Sept 4</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>Sept 3</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><u>S. Appleton</u> MD                                                                   |        |                                                                                                                                                             |                   | 22c. DATE SIGNED<br><u>Sept 4 1982</u>                              |       |                                                                |          |                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                     |  | 22e. ADDRESS                                                                                              |        |                                                                                                                                                             |                   |                                                                     |       |                                                                |          |                                                 |  |
| STEPHEN LYNN APPLETON                                                                                                                                                                                                                                                                                                                                                     |  | 3001 SOUTH HANOVER ST                                                                                     |        |                                                                                                                                                             |                   |                                                                     |       |                                                                |          |                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE                                                                                                 |        | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |       |                                                                |          |                                                 |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                    |  | 8/9/82                                                                                                    |        | Md Vet. Cem                                                                                                                                                 |                   | Crownsville Md                                                      |       |                                                                |          |                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                              |  | 25a. DATE REC'D. BY REGISTRAR                                                                             |        | 25b. REGISTRAR'S SIGNATURE                                                                                                                                  |                   |                                                                     |       |                                                                |          |                                                 |  |
| Wm C. March F/H 1101 E. North Ave                                                                                                                                                                                                                                                                                                                                         |  | SEP 8 1982                                                                                                |        | John J. Carver                                                                                                                                              |                   |                                                                     |       |                                                                |          |                                                 |  |





*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "REPORT" and "TABLE" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

3

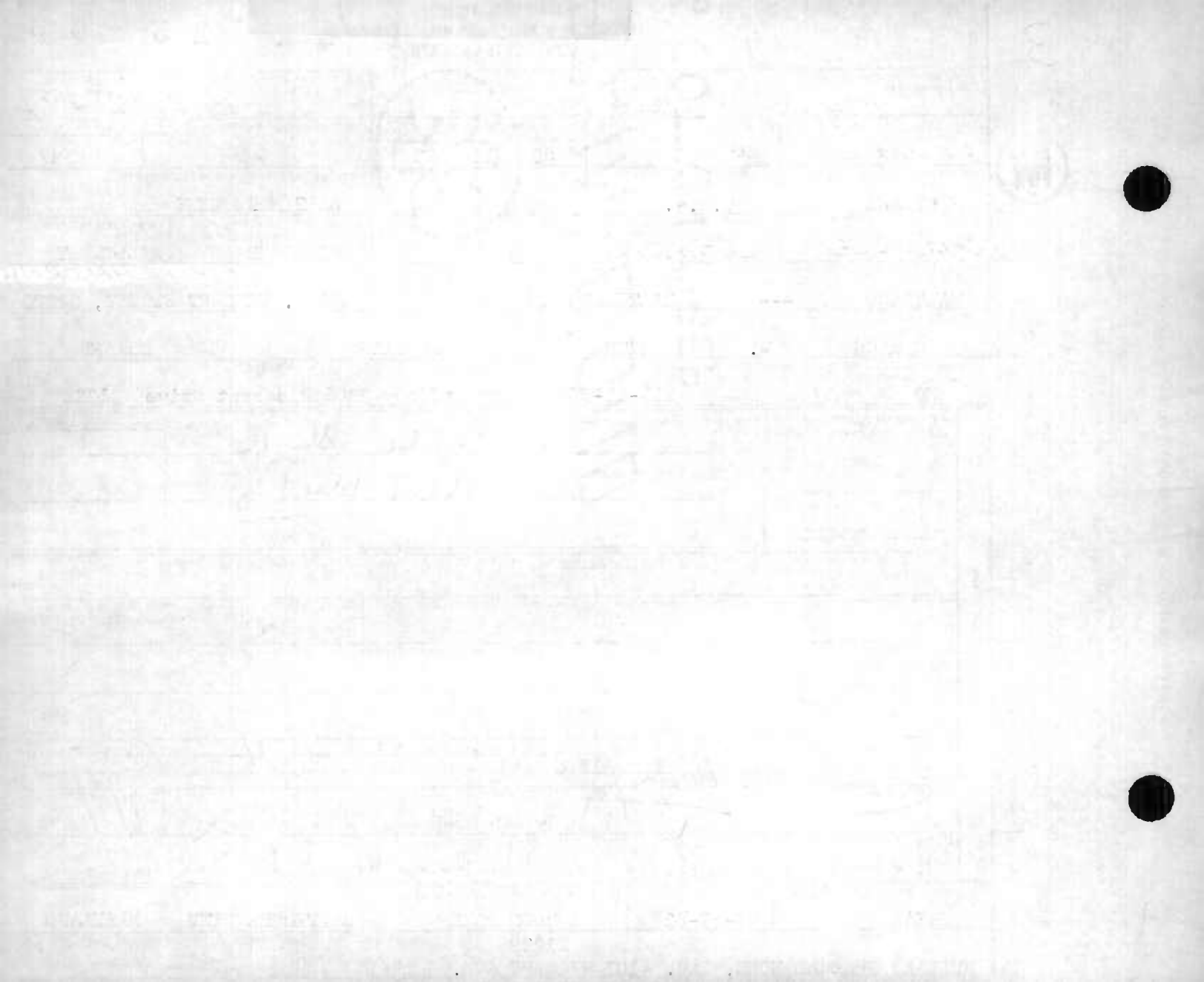
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300

29

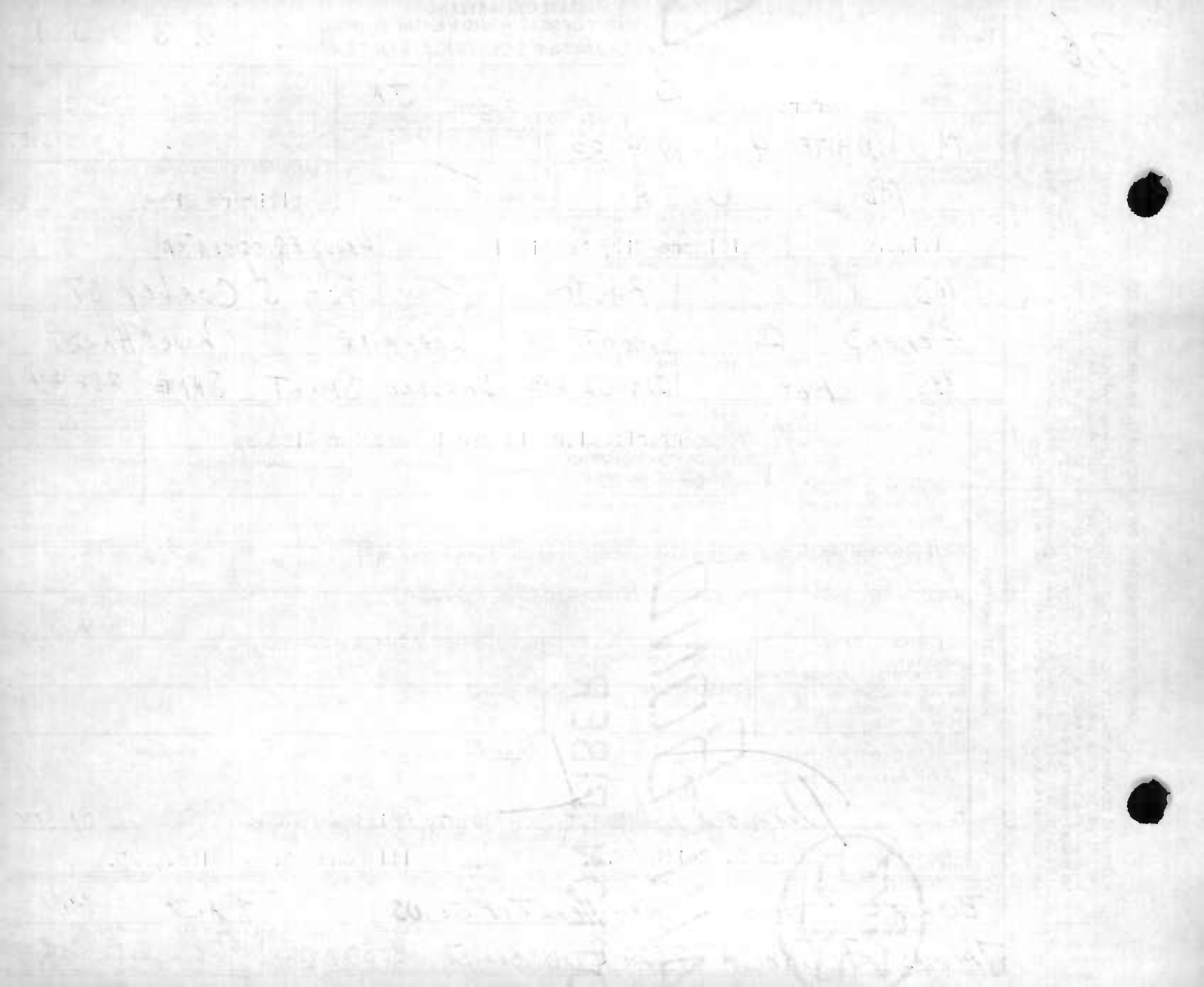
1

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                         |  |                                                                                                                       |  |                                                                                                                                                            |  |                                                                                     |  |                                                                                                                            |  | 8 2 2 3 5 0 0                                |                                                |                               |                                   |                                                                                                |                                  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|------------------------------------------------|-------------------------------|-----------------------------------|------------------------------------------------------------------------------------------------|----------------------------------|--|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                 |  | REG. NO.                                                                                                              |  |                                                                                                                                                            |  |                                                                                     |  |                                                                                                                            |  |                                              |                                                |                               |                                   |                                                                                                |                                  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                          |  | FIRST<br>JANE                                                                                                         |  | MIDDLE<br>ELIZA                                                                                                                                            |  | LAST<br>SMITHERS                                                                    |  | 2a. DATE OF DEATH MONTH<br>9                                                                                               |  |                                              | DAY<br>3                                       |                               | YEAR<br>82                        |                                                                                                | 2b. HOUR<br>255 AM               |  |  |
| 3 SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                              |  | 4 RACE<br>W                                                                                                           |  | 5 DATE OF BIRTH MONTH<br>08                                                                                                                                |  | DAY<br>12                                                                           |  | YEAR<br>22                                                                                                                 |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>60 YRS.    |                                                |                               | IF UNDER 1 YEAR<br>MONTHS<br>DAYS |                                                                                                | IF UNDER 24 HRS<br>HOURS<br>MIN. |  |  |
| 7 BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                          |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                 |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |                                                                                                                            |  |                                              |                                                |                               |                                   |                                                                                                |                                  |  |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LUTHERAN |  |                                                                                                                                                            |  |                                                                                     |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MILLINER                                                |  |                                              | 12b. KIND OF BUSINESS OR INDUSTRY<br>MILLINERY |                               |                                   |                                                                                                |                                  |  |  |
| 13a STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                       |  |                                                                                                                                                            |  |                                                                                     |  |                                                                                                                            |  | 13b COUNTY<br>---                            |                                                | 13c CITY OR TOWN<br>BALTIMORE |                                   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                  |  |  |
| 14 FATHER'S NAME<br>FIRST<br>HORACE                                                                                                                                                                                                                                                                                                          |  | MIDDLE<br>W.                                                                                                          |  | LAST<br>KEITH                                                                                                                                              |  | 15 MOTHER'S MAIDEN NAME<br>FIRST<br>HENRIETTA                                       |  | MIDDLE<br>---                                                                                                              |  | LAST<br>ECKERT                               |                                                |                               |                                   |                                                                                                |                                  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                    |  | 16b SOCIAL SECURITY NO.<br>217-12-5600                                                                                |  | 17 INFORMANT<br>Fay Gaffney 2206 Pleasant Drive 21228                                                                                                      |  |                                                                                     |  |                                                                                                                            |  |                                              |                                                |                               |                                   |                                                                                                |                                  |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>5789 IMMEDIATE CAUSE (a) Septic shock<br>DUE TO, OR AS A CONSEQUENCE OF UGI bleeding<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                                       |  |                                                                                                                                                            |  |                                                                                     |  |                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                                |                               |                                   |                                                                                                |                                  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).                                                                                                                                                                                                           |  |                                                                                                                       |  |                                                                                                                                                            |  |                                                                                     |  |                                                                                                                            |  |                                              |                                                |                               |                                   |                                                                                                |                                  |  |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                        |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                       |  |                                                                                                                                                            |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                              |                                                |                               |                                   |                                                                                                |                                  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                      |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>PM 19                                                               |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                     |  |                                                                                                                            |  |                                              |                                                |                               |                                   |                                                                                                |                                  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>                                                                                                                                                                                |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, GARM., ETC.)                                                |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                          |  |                                                                                     |  |                                                                                                                            |  |                                              |                                                |                               |                                   |                                                                                                |                                  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from 8/29 19 82 to 9/3 19 82, that (I) (we) lost the deceased alive on 9/3 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                      |  |                                                                                                                       |  |                                                                                                                                                            |  |                                                                                     |  |                                                                                                                            |  |                                              |                                                |                               |                                   |                                                                                                |                                  |  |  |
| 22b SIGNATURE<br>Henry J. Sacerio                                                                                                                                                                                                                                                                                                            |  | DEGREE<br>M.D.                                                                                                        |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |  | 22c DATE SIGNED<br>9/3/82                                                           |  |                                                                                                                            |  |                                              |                                                |                               |                                   |                                                                                                |                                  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Henry J. Sacerio                                                                                                                                                                                                                                                                                     |  | 22e ADDRESS<br>Lutheran Hospital of Baltimore                                                                         |  |                                                                                                                                                            |  |                                                                                     |  |                                                                                                                            |  |                                              |                                                |                               |                                   |                                                                                                |                                  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                           |  | 23b DATE<br>09-07-82                                                                                                  |  | 23c NAME OF CEMETERY OR CREMATORY<br>LOUDON PARK                                                                                                           |  |                                                                                     |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE CITY MARYLAND                                                       |  |                                              |                                                |                               |                                   |                                                                                                |                                  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>HUBBARD FUNERAL HOME, INC.                                                                                                                                                                                                                                                                                    |  | ADDRESS<br>4107 WILKENS AVE.                                                                                          |  | 25a DATE REC'D. BY REGISTRAR<br>SEP 7 1982                                                                                                                 |  | 25b REGISTRAR'S SIGNATURE<br>John J. Sacerio                                        |  |                                                                                                                            |  |                                              |                                                |                               |                                   |                                                                                                |                                  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                |         |                                                                                                         |  |                                                                                                                                                          |        |                                                                                              |                         |                                                               |                                           | REG. NO. 2 2 3 5 0 1                                                             |                                              |            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|---------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------|----------------------------------------------------------------------------------------------|-------------------------|---------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------------------------------|----------------------------------------------|------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                 |         | 1. DECEASED NAME (TYPE OR PRINT)                                                                        |  | FIRST                                                                                                                                                    | MIDDLE | LAST                                                                                         | 2b. DATE KNOWN OF DEATH |                                                               | <input checked="" type="checkbox"/> MONTH | DAY                                                                              | YEAR                                         | 2b. HOUR   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |         | Gerard G. Smoot JR.                                                                                     |  |                                                                                                                                                          |        |                                                                                              | 9 22 19 82              |                                                               |                                           |                                                                                  |                                              |            |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE | 5. DATE OF BIRTH                                                                                        |  | 6. AGE (IN YEARS)                                                                                                                                        |        | IF UNDER 1 YR.                                                                               |                         | IF UNDER 24 HRS.                                              |                                           | 7c. DATE PRONOUNCED DEAD                                                         |                                              | 7d. HOUR   |
| M                                                                                                                                                                                                                                                                                                                                                                                                                                      | WHITE   | 4-3-1949                                                                                                |  | 33 YRS.                                                                                                                                                  |        |                                                                                              |                         |                                                               |                                           | 9 22 19 82                                                                       |                                              | 3:57 PM    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                              |         | 7b. CITIZEN OF WHAT COUNTRY?                                                                            |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |        | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                         |                         |                                                               |                                           |                                                                                  |                                              |            |
| MD.                                                                                                                                                                                                                                                                                                                                                                                                                                    |         | U.S.A.                                                                                                  |  |                                                                                                                                                          |        | Baltimore City, MD.                                                                          |                         |                                                               |                                           |                                                                                  |                                              |            |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                              |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                          |        |                                                                                              |                         | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                                           | 12b. KIND OF BUSINESS OR INDUSTRY                                                |                                              |            |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                              |         | Baltimore City Hospital                                                                                 |  |                                                                                                                                                          |        |                                                                                              |                         | Heavy Eq. Operator                                            |                                           |                                                                                  |                                              |            |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                             |         | 13b. COUNTY                                                                                             |  | 13c. CITY OR TOWN                                                                                                                                        |        | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                         | 13e. STREET ADDRESS                                           |                                           |                                                                                  |                                              |            |
| MD.                                                                                                                                                                                                                                                                                                                                                                                                                                    |         |                                                                                                         |  | BALTO.                                                                                                                                                   |        |                                                                                              |                         | 930 S. Curley ST.                                             |                                           |                                                                                  |                                              |            |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                      |         |                                                                                                         |  | 15. MOTHER'S MAIDEN NAME                                                                                                                                 |        |                                                                                              |                         |                                                               |                                           |                                                                                  |                                              |            |
| GERARD G. SMOOT SR.                                                                                                                                                                                                                                                                                                                                                                                                                    |         |                                                                                                         |  | LORRAINE LUCKHARDT                                                                                                                                       |        |                                                                                              |                         |                                                               |                                           |                                                                                  |                                              |            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                     |         |                                                                                                         |  | 16b. SOCIAL SECURITY NO.                                                                                                                                 |        | 17. INFORMANT ADDRESS                                                                        |                         |                                                               |                                           |                                                                                  |                                              |            |
| YES 1969                                                                                                                                                                                                                                                                                                                                                                                                                               |         |                                                                                                         |  | 213-52-2884                                                                                                                                              |        | DARLENE SMOOT SAME 21224                                                                     |                         |                                                               |                                           |                                                                                  |                                              |            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                              |         |                                                                                                         |  |                                                                                                                                                          |        |                                                                                              |                         |                                                               |                                           |                                                                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |            |
| PART I DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                                                                                            |         |                                                                                                         |  |                                                                                                                                                          |        |                                                                                              |                         |                                                               |                                           |                                                                                  |                                              |            |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease                                                                                                                                                                                                                                                                                                                                                                            |         |                                                                                                         |  |                                                                                                                                                          |        |                                                                                              |                         |                                                               |                                           |                                                                                  |                                              |            |
| 4292 } DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                  |         |                                                                                                         |  |                                                                                                                                                          |        |                                                                                              |                         |                                                               |                                           |                                                                                  |                                              |            |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.                                                                                                                                                                                                                                                                                                                                          |         |                                                                                                         |  |                                                                                                                                                          |        |                                                                                              |                         |                                                               |                                           |                                                                                  |                                              |            |
| (b) } DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                   |         |                                                                                                         |  |                                                                                                                                                          |        |                                                                                              |                         |                                                               |                                           |                                                                                  |                                              |            |
| (c) }                                                                                                                                                                                                                                                                                                                                                                                                                                  |         |                                                                                                         |  |                                                                                                                                                          |        |                                                                                              |                         |                                                               |                                           |                                                                                  |                                              |            |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).                                                                                                                                                                                                                                                                                                    |         |                                                                                                         |  |                                                                                                                                                          |        |                                                                                              |                         |                                                               |                                           |                                                                                  |                                              |            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |         |                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                        |        |                                                                                              |                         |                                                               |                                           | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                              |            |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                    |         |                                                                                                         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                                                                             |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |                         |                                                               |                                           |                                                                                  |                                              |            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |         |                                                                                                         |  | P.M. 19                                                                                                                                                  |        |                                                                                              |                         |                                                               |                                           |                                                                                  |                                              |            |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                 |         |                                                                                                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                              |        | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                               |                         |                                                               |                                           |                                                                                  |                                              |            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |         |                                                                                                         |  |                                                                                                                                                          |        |                                                                                              |                         |                                                               |                                           |                                                                                  |                                              |            |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                                                                                                         |  |                                                                                                                                                          |        |                                                                                              |                         |                                                               |                                           |                                                                                  |                                              |            |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                       |         |                                                                                                         |  | TITLE (SPECIFY)                                                                                                                                          |        |                                                                                              |                         |                                                               |                                           | DATE SIGNED                                                                      |                                              |            |
| Thomas D. Smith                                                                                                                                                                                                                                                                                                                                                                                                                        |         |                                                                                                         |  | M.D. Deputy Chief                                                                                                                                        |        |                                                                                              |                         |                                                               |                                           | 9/23/82                                                                          |                                              |            |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                        |         |                                                                                                         |  | ADDRESS                                                                                                                                                  |        |                                                                                              |                         |                                                               |                                           |                                                                                  |                                              |            |
| Thomas D. Smith, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                  |         |                                                                                                         |  | 111 Penn St. Balto., MD.                                                                                                                                 |        |                                                                                              |                         |                                                               |                                           |                                                                                  |                                              |            |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE IF)                                                                                                                                                                                                                                                                                                                                                                                              |         | 23b. DATE                                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |        |                                                                                              |                         | 23d. LOCATION CITY OR TOWN                                    |                                           | COUNTY                                                                           |                                              | 23e. STATE |
| BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                 |         | 9-25-82                                                                                                 |  | SAC. HEART OF JESUS                                                                                                                                      |        |                                                                                              |                         | BALTO.                                                        |                                           | MD.                                                                              |                                              |            |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                                                                              |         |                                                                                                         |  |                                                                                                                                                          |        | 25a. DATE REC'D. BY REGISTRAR                                                                |                         | 25b. REGISTRAR'S SIGNATURE                                    |                                           |                                                                                  |                                              |            |
| THOMAS J. SKARDA                                                                                                                                                                                                                                                                                                                                                                                                                       |         |                                                                                                         |  |                                                                                                                                                          |        | SEP 24 1982                                                                                  |                         | John J. Conner                                                |                                           |                                                                                  |                                              |            |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is to be completely filled in by the funeral director. It should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 5 0 2

REG. NO.

|                                                                                                                                                                                                                                                                                                                             |                                                                                                           |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                               |                                                                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                         |                                                                                                           | FIRST MIDDLE LAST                                                                                                                                           |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                           |  | 2b. HOUR                                                                                                                      |                                                                        |
| LEORIA SNIPES                                                                                                                                                                                                                                                                                                               |                                                                                                           |                                                                                                                                                             |  | 09/02/82                                                                                                                                   |  | 4:40P                                                                                                                         |                                                                        |
| 3. SEX                                                                                                                                                                                                                                                                                                                      | 4. RACE                                                                                                   | 5. DATE OF BIRTH                                                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                                            |  | IF UNDER 1 YEAR                                                                                                               |                                                                        |
| Female                                                                                                                                                                                                                                                                                                                      | Black                                                                                                     | 9-4/1919 YEAR                                                                                                                                               |  | 62                                                                                                                                         |  | MONTHS DAYS HOURS MIN.                                                                                                        |                                                                        |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                   | 7b. CITIZEN OF WHAT COUNTRY?                                                                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                       |  |                                                                                                                               |                                                                        |
| Alabama                                                                                                                                                                                                                                                                                                                     | U.S.A.                                                                                                    |                                                                                                                                                             |  | BALTIMORE CITY MD.                                                                                                                         |  |                                                                                                                               |                                                                        |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                             |                                                                        |
| BALTIMORE                                                                                                                                                                                                                                                                                                                   | JOHNS HOPKINS HOSPITAL                                                                                    |                                                                                                                                                             |  | Housewife                                                                                                                                  |  |                                                                                                                               |                                                                        |
| 13a. STATE                                                                                                                                                                                                                                                                                                                  |                                                                                                           | 13b. COUNTY                                                                                                                                                 |  | 13c. CITY OR TOWN                                                                                                                          |  | 13d. STREET ADDRESS                                                                                                           |                                                                        |
| Md.                                                                                                                                                                                                                                                                                                                         |                                                                                                           |                                                                                                                                                             |  | Balto.                                                                                                                                     |  | 3410 Menlo Drive 21215                                                                                                        |                                                                        |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                      |                                                                                                           | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                                                                               |  |                                                                                                                                            |  |                                                                                                                               |                                                                        |
|                                                                                                                                                                                                                                                                                                                             |                                                                                                           |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                               |                                                                        |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                                                                                                                                                                                                                            |                                                                                                           | 16b. SOCIAL SECURITY NO.                                                                                                                                    |  | 17. INFORMANT ADDRESS                                                                                                                      |  |                                                                                                                               |                                                                        |
| no                                                                                                                                                                                                                                                                                                                          |                                                                                                           | 420-20-6582                                                                                                                                                 |  | George Snipes 3410 Menlo Dr.                                                                                                               |  |                                                                                                                               |                                                                        |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>4589 IMMEDIATE CAUSE (a) HYPOTENSION<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) SEPTIC SHOCK<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) INFECTION OF RIGHT LEG                                                     |                                                                                                           |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>6 HOURS<br>24 HOURS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br>DIABETES MELLITUS                                                                                                                                                                   |                                                                                                           |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                               |                                                                        |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                      |                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                        |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                    |                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                                                             |  |                                                                                                                               |                                                                        |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                |                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |  |                                                                                                                               |                                                                        |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-2-82, 19____, to 9-2-82, 19____, that (I) (we) last saw the deceased alive on 9-2-82, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                           |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                               |                                                                        |
| 22b. SIGNATURE<br>Routy                                                                                                                                                                                                                                                                                                     |                                                                                                           | DEGREE                                                                                                                                                      |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>9-2-82                                                                                                    |                                                                        |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>OIKAWA                                                                                                                                                                                                                                                                             |                                                                                                           | 22e. ADDRESS<br>JOHNS HOPKINS HOSPITAL                                                                                                                      |  |                                                                                                                                            |  |                                                                                                                               |                                                                        |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                      |                                                                                                           | 23b. DATE<br>9/7/82                                                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.                                                                                      |  | 23d. LOCATION<br>Westport, B.B. MD. STATE                                                                                     |                                                                        |
| 24. FUNERAL DIRECTOR<br>NAME<br>Chas. A. Rice FSPA 1300 Eutaw Pl                                                                                                                                                                                                                                                            |                                                                                                           |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 14 1982                                                                                               |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Carver                                                                                  |                                                                        |

1912

1912

1912



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                            |  |  |                                                                                                        |  |  |                                                                                                                                                          |  |  |                                                                | 8 2 2 3 5 0 3                                |  |                   |                                                                     |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------|----------------------------------------------|--|-------------------|---------------------------------------------------------------------|--|-----------------|-----------------------------------|--|-------|--|--|--------|--|--|----------|--|--|
| 1 - FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                         |  |  |                                                                                                        |  |  |                                                                                                                                                          |  |  |                                                                | REG. NO.                                     |  |                   |                                                                     |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                             |  |  | FIRST                                                                                                  |  |  | MIDDLE                                                                                                                                                   |  |  | LAST                                                           |                                              |  | 2a. DATE OF DEATH |                                                                     |  | MONTH           |                                   |  | DAY   |  |  | YEAR   |  |  | 2b. HOUR |  |  |
| Marie                                                                                                                                                                                                                                                                                                           |  |  | Snowden                                                                                                |  |  |                                                                                                                                                          |  |  |                                                                |                                              |  | 9/20/82           |                                                                     |  |                 |                                   |  |       |  |  | 545 AM |  |  |          |  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                          |  |  | 4. RACE                                                                                                |  |  | 5. DATE OF BIRTH                                                                                                                                         |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |                                              |  | IF UNDER 1 YEAR   |                                                                     |  | IF UNDER 24 HRS |                                   |  |       |  |  |        |  |  |          |  |  |
| F                                                                                                                                                                                                                                                                                                               |  |  | B                                                                                                      |  |  | 12-16-1882                                                                                                                                               |  |  | 99                                                             |                                              |  | MONTHS            |                                                                     |  | DAYS            |                                   |  | HOURS |  |  | MIN.   |  |  |          |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                       |  |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |                                              |  |                   |                                                                     |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
| Unkn                                                                                                                                                                                                                                                                                                            |  |  | USA                                                                                                    |  |  |                                                                                                                                                          |  |  | Baltimore City MD.                                             |                                              |  |                   |                                                                     |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                       |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |                                                                                                                                                          |  |  |                                                                |                                              |  |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |                 | 12b. KIND OF BUSINESS OR INDUSTRY |  |       |  |  |        |  |  |          |  |  |
| Baltimore                                                                                                                                                                                                                                                                                                       |  |  | Jewish Conv. Home                                                                                      |  |  |                                                                                                                                                          |  |  |                                                                |                                              |  |                   |                                                                     |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                         |  |  |                                                                                                        |  |  |                                                                                                                                                          |  |  |                                                                | 13a. INSIDE CITY LIMITS?                     |  |                   | 13b. STREET ADDRESS                                                 |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                      |  |  |                                                                                                        |  |  |                                                                                                                                                          |  |  |                                                                | 13b. COUNTY                                  |  |                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                 | Jewish Convalescent Home          |  |       |  |  |        |  |  |          |  |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                               |  |  |                                                                                                        |  |  |                                                                                                                                                          |  |  |                                                                | 15. MOTHER'S MAIDEN NAME                     |  |                   |                                                                     |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
| First MIDDLE LAST                                                                                                                                                                                                                                                                                               |  |  |                                                                                                        |  |  |                                                                                                                                                          |  |  |                                                                | First MIDDLE LAST                            |  |                   |                                                                     |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
| Unknown                                                                                                                                                                                                                                                                                                         |  |  |                                                                                                        |  |  |                                                                                                                                                          |  |  |                                                                | Unknown                                      |  |                   |                                                                     |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                               |  |  | 16b. SOCIAL SECURITY NO.                                                                               |  |  | 17. INFORMANT                                                                                                                                            |  |  | ADDRESS                                                        |                                              |  |                   |                                                                     |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
| No                                                                                                                                                                                                                                                                                                              |  |  | 212-32-1220A                                                                                           |  |  | Unknown                                                                                                                                                  |  |  |                                                                |                                              |  |                   |                                                                     |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ASCVD                                                                                                                                                                                  |  |  |                                                                                                        |  |  |                                                                                                                                                          |  |  |                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                   |                                                                     |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
| 4292                                                                                                                                                                                                                                                                                                            |  |  |                                                                                                        |  |  |                                                                                                                                                          |  |  |                                                                |                                              |  |                   |                                                                     |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                  |  |  |                                                                                                        |  |  |                                                                                                                                                          |  |  |                                                                |                                              |  |                   |                                                                     |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                                                                                                                                                                                   |  |  |                                                                                                        |  |  |                                                                                                                                                          |  |  |                                                                |                                              |  |                   |                                                                     |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                  |  |  |                                                                                                        |  |  |                                                                                                                                                          |  |  |                                                                |                                              |  |                   |                                                                     |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
| (c)                                                                                                                                                                                                                                                                                                             |  |  |                                                                                                        |  |  |                                                                                                                                                          |  |  |                                                                |                                              |  |                   |                                                                     |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) D.M.                                                                                                                                                                        |  |  |                                                                                                        |  |  |                                                                                                                                                          |  |  |                                                                |                                              |  |                   |                                                                     |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                          |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  |  | 20a. AUTOPSY?                                                                                                                                            |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                              |  |                   |                                                                     |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
|                                                                                                                                                                                                                                                                                                                 |  |  |                                                                                                        |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                 |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                              |  |                   |                                                                     |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                              |  |  | 21b. TIME OF INJURY                                                                                    |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |  |                                                                |                                              |  |                   |                                                                     |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
|                                                                                                                                                                                                                                                                                                                 |  |  | HOUR A.M. MONTH DAY YEAR                                                                               |  |  |                                                                                                                                                          |  |  |                                                                |                                              |  |                   |                                                                     |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
|                                                                                                                                                                                                                                                                                                                 |  |  | P.M.                                                                                                   |  |  | 19                                                                                                                                                       |  |  |                                                                |                                              |  |                   |                                                                     |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                            |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  | 21f. LOCATION                                                                                                                                            |  |  | CITY OR TOWN                                                   |                                              |  | COUNTY            |                                                                     |  | STATE           |                                   |  |       |  |  |        |  |  |          |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                               |  |  |                                                                                                        |  |  | STREET                                                                                                                                                   |  |  |                                                                |                                              |  |                   |                                                                     |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 01-21, 1982, to 09-20, 1982, that (we) last saw the deceased alive on 09-20, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (each) (did not) view the body after death. |  |  |                                                                                                        |  |  |                                                                                                                                                          |  |  |                                                                |                                              |  |                   |                                                                     |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                  |  |  | DEGREE                                                                                                 |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  |  | 22c. DATE SIGNED                                               |                                              |  |                   |                                                                     |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
|                                                                                                                                                                                                                                                                                                                 |  |  |                                                                                                        |  |  |                                                                                                                                                          |  |  | 8/20/82                                                        |                                              |  |                   |                                                                     |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                           |  |  | 22e. ADDRESS                                                                                           |  |  |                                                                                                                                                          |  |  |                                                                |                                              |  |                   |                                                                     |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
| A. J. VERKUN MD                                                                                                                                                                                                                                                                                                 |  |  | 3640 Forbes Lane                                                                                       |  |  | 21245                                                                                                                                                    |  |  |                                                                |                                              |  |                   |                                                                     |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                       |  |  | 23b. DATE                                                                                              |  |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  |  | 23d. LOCATION                                                  |                                              |  | CITY OR TOWN      |                                                                     |  | COUNTY          |                                   |  | STATE |  |  |        |  |  |          |  |  |
| Burial                                                                                                                                                                                                                                                                                                          |  |  | 9/28/82                                                                                                |  |  | Mt. Zion Cem.                                                                                                                                            |  |  | Landsdown,                                                     |                                              |  |                   |                                                                     |  | Md.             |                                   |  |       |  |  |        |  |  |          |  |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                            |  |  |                                                                                                        |  |  |                                                                                                                                                          |  |  |                                                                | 25a. DATE REC'D. BY REGISTRAR                |  |                   | 25b. REGISTRAR'S SIGNATURE                                          |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
| NAME ADDRESS                                                                                                                                                                                                                                                                                                    |  |  |                                                                                                        |  |  |                                                                                                                                                          |  |  |                                                                |                                              |  |                   |                                                                     |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |
| Win C March F/H, Inc. 1101 E. North Ave.                                                                                                                                                                                                                                                                        |  |  |                                                                                                        |  |  |                                                                                                                                                          |  |  |                                                                | SEP 28 1982                                  |  |                   | John J. Carver                                                      |  |                 |                                   |  |       |  |  |        |  |  |          |  |  |



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

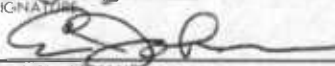
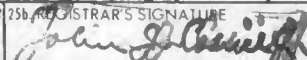
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 165 42 42  
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filled in by the funeral director. Pages 165 42 42  
should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 165 42 42  
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once. Pages 165 42 42

BP\_\_\_\_\_

DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                |  |                                                                        |  | 8 2 2 3 5 0 4<br>REG. NO.                                                                                                                                      |  |                                                                                                                                       |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>FRANCIS L SOMERS</b>                                                                                                                                                                                                                                                                                                                                      |  |                                                                        |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>SEPTEMBER 22, 1982</b>                                                                                               |  |                                                                                                                                       |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                        |  | 2b. HOUR<br><b>11:58pm</b>                                                                                                                                     |  |                                                                                                                                       |  |
| 4. RACE<br><b>White</b>                                                                                                                                                                                                                                                                                                                                                                             |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 7 1915</b>                  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS                                                                                                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 74 HRS<br>HOURS MIN.                                                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                             |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |  |                                                                                                                                       |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                                                                                                                                                                                                                                                                                                   |  |                                                                        |  | 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                  |  |                                                                                                                                       |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b>                                                                                                                                                                                                                                                      |  |                                                                        |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Inventory Control</b>                                                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CLERK</b>                                                                                     |  |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                        |  | 13b. CITY OR TOWN<br><b>SOMERSET</b>                                                                                                                           |  | 13c. STREET ADDRESS<br><b>108 Chesapeake Ave.</b>                                                                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>KIRK V. Somers</b>                                                                                                                                                                                                                                                                                                                                     |  |                                                                        |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>GLADYTH Dilley Somers</b>                                                                                  |  |                                                                                                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                                  |  |                                                                        |  | 16b. SOCIAL SECURITY NO.<br><b>215-05-7019</b>                                                                                                                 |  | 17. INFORMANT<br>ADDRESS<br><b>PATSY STERLING Box 190A CRISFIELD, MD.</b>                                                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4149 IMMEDIATE CAUSE (a) Ventricular tachycardia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Severe Coronary Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                        |  |                                                                                                                                                                |  |                                                                                                                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                 |  |                                                                        |  |                                                                                                                                                                |  |                                                                                                                                       |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                            |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                 |  |                                                                                                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/18</b> , 19 <b>82</b> , to <b>9/22</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>9/22</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)                                           |  |                                                                        |  |                                                                                                                                                                |  |                                                                                                                                       |  |
| 22b. SIGNATURE<br>                                                                                                                                                                                                                                                                                               |  |                                                                        |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>9/23/82</b>                                                                                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ERIC JOHNSON</b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                        |  | 22e. ADDRESS<br><b>John Hopkins Hospital</b>                                                                                                                   |  |                                                                                                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br><b>Sept 26, 1982</b>                                      |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sunnynridge</b>                                                                                                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>CRISFIELD Somerset Md.</b>                                                           |  |
| 24. FUNERAL DIRECTOR<br>(NAME) ADDRESS<br><b>Gregory C. Sterling Crisfield, Md.</b>                                                                                                                                                                                                                                                                                                                 |  |                                                                        |  | 25a. SEP 27 1982                                                                                                                                               |  | 25b. REGISTRAR'S SIGNATURE<br>                   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical investigation will be required by law.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                |  |                                                                                                                                                                |                                                                 |                                                                                                 |                                                                  |                                                                                                                            |  | 8 2 2 3 5 0 5                                               |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------|--|
| FOR<br>1. STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                |  | REG. NO.                                                                                                                                       |  |                                                                                                                                                                |                                                                 |                                                                                                 |                                                                  |                                                                                                                            |  |                                                             |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LARRY</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                |  |                                                                                                                                                                | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>SEPTEMBER 17 1982</b> |                                                                                                 |                                                                  |                                                                                                                            |  | 2b. HOUR<br><b>07:20AM</b>                                  |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br><b>Black</b>                                                                                                                        |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 8 49</b>                                                                                                            |                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>33</b> YRS                                                |                                                                  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                          |  | 7. IF UNDER 24 HRS<br>HOURS MIN.                            |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                     |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |                                                                  |                                                                                                                            |  |                                                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |                                                                                                                                                                |                                                                 |                                                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                           |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                               |  | 13b. COUNTY                                                                                                                                    |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                          |                                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                  | 13e. STREET ADDRESS<br><b>2625 Tyler Avenue</b>                                                                            |  |                                                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Melvin Sorrell</b>                                                                                                                                                                                                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lillie M. Moore</b>                                                                        |  |                                                                                                                                                                |                                                                 |                                                                                                 |                                                                  |                                                                                                                            |  |                                                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br><b>216-54-3067</b>                                                                                                 |  | 17. INFORMANT<br><b>Roslyn Sorrell 4403 Marble Hall apt 21</b>                                                                                                 |                                                                 |                                                                                                 |                                                                  |                                                                                                                            |  |                                                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1991</b> IMMEDIATE CAUSE (a) <b>respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>disseminated adenocarcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br><b>6/82</b> |  |                                                                                                                                                |  |                                                                                                                                                                |                                                                 |                                                                                                 |                                                                  |                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>9/14</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>1</b>                                                                                                                                                                                                                                                                   |  |                                                                                                                                                |  |                                                                                                                                                                |                                                                 |                                                                                                 |                                                                  |                                                                                                                            |  |                                                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                               |  |                                                                                                                                                                |                                                                 | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                 |                                                                 |                                                                                                 |                                                                  |                                                                                                                            |  |                                                             |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>204m 25AM</b>                                                                                          |                                                                 |                                                                                                 |                                                                  |                                                                                                                            |  |                                                             |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>Sept 14 1982</b> to <b>Sept 17 1982</b> that (1) (we) last saw the deceased alive on <b>Sept 17 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.                                                                     |  |                                                                                                                                                |  |                                                                                                                                                                |                                                                 |                                                                                                 |                                                                  |                                                                                                                            |  |                                                             |  |
| 22b. SIGNATURE<br><b>Scot C. Remick</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                 |                                                                                                 |                                                                  | 22c. DATE SIGNED<br><b>9/17/82</b>                                                                                         |  |                                                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SCOT C. REMICK</b>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                |  | 22e. ADDRESS<br><b>600 N. WOLFE ST. BALT. MD 21205</b>                                                                                                         |                                                                 |                                                                                                 |                                                                  |                                                                                                                            |  |                                                             |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b>                                                                                                                                                                                                                                                                                                                                            |  | 23b. DATE<br><b>9/23/82</b>                                                                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Pk.</b>                                                                                                 |                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                              |                                                                  | 25a. DATE OF RECORD BY REGISTRAR<br><b>SEP 21 1982</b>                                                                     |  |                                                             |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Avenue</b>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Laniel</b>                                                                                                            |                                                                 |                                                                                                 |                                                                  |                                                                                                                            |  |                                                             |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows only injury, or other traumatic event, the medical examiner will then certify the cause of death.

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 5 0 6  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                               |                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARIE</b>                                                                                                                                                                                                                                                                                                                                                                 |  | FIRST<br><b>SORRELL</b>                                                                                                                |  | LAST                                                                                                                                                        |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09-17-82</b>                                          |  | 2b. HOUR<br><b>12<sup>25</sup> AM</b>                                                                                         |                                                 |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br><b>Black</b>                                                                                                                |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 22 20</b>                                                                                                       |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.                                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                     |                                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. Carolina</b>                                                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                             |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE City</b> MD.                               |  |                                                                                                                               |                                                 |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                             |                                                 |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                       |  | 13b. COUNTY                                                                                                                            |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3926 Norfolk Ave. 2nd Fl.</b>                                                                       |                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ernest Leach</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Codey</b>                                                                                          |  |                                                                                                 |  |                                                                                                                               |                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br><b>218-36-9166</b>                                                                                                              |  | 17. INFORMANT<br>ADDRESS<br><b>Alice Johnson 3926 Norfolk Ave. 2nd fl</b>                       |  |                                                                                                                               |                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CORONARY STANDSTILL</b><br><b>2765</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ACUTE RENAL FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>INTRAVASCULAR VOLUME DEPLETION</b>                                                                                       |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>                                                                                                                                                                                                                                                                        |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                               |                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                            |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                 |  |                                                                                                                               |                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                               |                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>SEPT. 12<sup>th</sup></b> , 19 <b>82</b> , to <b>SEPT 17<sup>th</sup></b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>SEPT 17<sup>th</sup></b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                               |                                                 |
| 22b. SIGNATURE<br><b>BEN MAGNUS-LAWSON MD</b>                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                        |  | DEGREE                                                                                                                                                      |  |                                                                                                 |  | 22c. DATE SIGNED<br><b>9-17-82</b>                                                                                            |                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BEN MAGNUS-LAWSON MD</b>                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                        |  | 22e. ADDRESS<br><b>PROV. HOSPITAL BALTIMORE</b>                                                                                                             |  |                                                                                                 |  |                                                                                                                               |                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                       |  | 23b. DATE<br><b>9/22/82</b>                                                                                                            |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Pk.</b>                                                                                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                              |  |                                                                                                                               |                                                 |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Avenue</b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 21 1982</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>                                             |  |                                                                                                                               |                                                 |



UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 5 0 7

REG. NO.

|                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                 |  | 2a. DATE OF DEATH                                                                                      |  | MONTH DAY YEAR                                                                                                                                           |  | 2b. HOUR                                                       |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                       |  | FIRST MIDDLE LAST                                                                                      |  | 9 16 82                                                                                                                                                  |  | 622 PM                                                         |  |
| JAMES E SPICER                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |  |
| 3. SEX                                                                                                                                                                                                                                                                                                 |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| MALE                                                                                                                                                                                                                                                                                                   |  | W                                                                                                      |  | MONTH DAY YEAR                                                                                                                                           |  | 28                                                             |  |
|                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  | 07 29 54                                                                                                                                                 |  | YRS. MONTHS DAYS HOURS MIN.                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| DELAWARE                                                                                                                                                                                                                                                                                               |  | USA                                                                                                    |  |                                                                                                                                                          |  | BALTIMORE CITY MD.                                             |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| BALTIMORE                                                                                                                                                                                                                                                                                              |  | UNIVERSITY OF MD                                                                                       |  | TECHNICIAN                                                                                                                                               |  |                                                                |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                |  | 13a. STATE                                                                                             |  | 13b. COUNTY                                                                                                                                              |  | 13c. CITY OR TOWN                                              |  |
|                                                                                                                                                                                                                                                                                                        |  | DELAWARE                                                                                               |  |                                                                                                                                                          |  | LAVRELL                                                        |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME                                                                               |  | 13d. INSIDE CITY LIMITS?                                                                                                                                 |  | 13e. STREET ADDRESS                                            |  |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                      |  | FIRST MIDDLE LAST                                                                                      |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                 |  | RT 2, Box 382B                                                 |  |
| NORMAN SPICER                                                                                                                                                                                                                                                                                          |  | SUSIE JEFFERSON                                                                                        |  |                                                                                                                                                          |  |                                                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.                                                                               |  | 17. INFORMANT                                                                                                                                            |  | ADDRESS                                                        |  |
| UNKNOWN                                                                                                                                                                                                                                                                                                |  | 221-44-1861                                                                                            |  | LINDA J. SPICER                                                                                                                                          |  | R2 B1382B LAVRELL DEL 1995                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                              |  | PART I. DEATH WAS CAUSED BY:                                                                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                             |  |                                                                |  |
| 2080                                                                                                                                                                                                                                                                                                   |  | IMMEDIATE CAUSE (a) MASSIVE INTRACEREBRAL HEMORRHAGE                                                   |  |                                                                                                                                                          |  |                                                                |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                         |  | (b) DUE TO, OR AS A CONSEQUENCE OF THROMBOCYTOPENIA                                                    |  |                                                                                                                                                          |  |                                                                |  |
|                                                                                                                                                                                                                                                                                                        |  | (c) DUE TO, OR AS A CONSEQUENCE OF ACUTE LEUKEMIA                                                      |  |                                                                                                                                                          |  |                                                                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY?                                                                                                                                            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                 |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                     |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                |  |
|                                                                                                                                                                                                                                                                                                        |  | P.M. 19                                                                                                |  |                                                                                                                                                          |  |                                                                |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION CITY OR TOWN COUNTY STATE                                                                                                                  |  |                                                                |  |
|                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/25/82, to 9/16/82, that (I) (we) last saw the deceased alive on 9/16/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (I) did (I did not) wash the body after death. |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                         |  | DEGREE                                                                                                 |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED                                               |  |
|                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                          |  | 9/16/82                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                  |  | 22e. ADDRESS                                                                                           |  |                                                                                                                                                          |  |                                                                |  |
| THEKMEOTIAN                                                                                                                                                                                                                                                                                            |  | UNIVERSITY OF MD CANCER CENTER                                                                         |  |                                                                                                                                                          |  |                                                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                              |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| Burial                                                                                                                                                                                                                                                                                                 |  | 9-19-82                                                                                                |  | ODD fellows Cemetery                                                                                                                                     |  | Sexton Sussex Del                                              |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                              |  | ADDRESS                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
| H. L. DASHAROOD                                                                                                                                                                                                                                                                                        |  | Box 678 LAVRELL Del 19956                                                                              |  | SEP 22 1982                                                                                                                                              |  | James J. Conner                                                |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at 410-388-1111.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DHMM - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                     |  |                                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                          |                                                               |                                                                                                 |                                                   | 8 2 2 3 5 0 8                                                                                                              |  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                          |                                                               |                                                                                                 |                                                   | REG. NO.                                                                                                                   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HEWLETT OLIVER SPIRES, SR.</b>                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                          | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>September 26, 1982</b> |                                                                                                 |                                                   | 2b. HOUR<br><b>M</b>                                                                                                       |  |  |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br><b>White</b>                                                                                                                         |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 12, 1909</b>                                                                                                 |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b>                                             |                                                               | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>                                                   |                                                   | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>MD</b>                                                                                |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Mississippi</b>                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                            |                                                               |                                                                                                 |                                                   |                                                                                                                            |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>So. Baltimore General Hosp.</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Dept. Manager</b> |                                                               |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Sears</b> |                                                                                                                            |  |  |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                 |  | 13b. COUNTY<br><b>Anne Arundel</b>                                                                                                                          |  | 13c. CITY OR TOWN<br><b>Glen Burnie</b>                                                  |                                                               | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                   | 13e. STREET ADDRESS<br><b>7947 Myers Dr. 21061</b>                                                                         |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas F. Spires</b>                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                 |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sallie J. Morgan</b>                                                                                    |  |                                                                                          |                                                               |                                                                                                 |                                                   |                                                                                                                            |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>N/A</b>                                                                           |  | 17. INFORMANT (Son) ADDRESS<br><b>Mr. Hewlett O. Spires, Jr. # 13</b>                                                                                       |  |                                                                                          |                                                               | Same as                                                                                         |                                                   |                                                                                                                            |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <b>myocardial infarction</b>                                                                                                                                                                                |  |                                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                          |                                                               |                                                                                                 |                                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b>                                                           |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____                                                                                                                                                                   |  |                                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                          |                                                               |                                                                                                 |                                                   |                                                                                                                            |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>DM; Arteriosclerosis</b>                                                                                                                                                                                        |  |                                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                          |                                                               |                                                                                                 |                                                   |                                                                                                                            |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                                                          |                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                  |  |                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)           |                                                               |                                                                                                 |                                                   |                                                                                                                            |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                           |  |                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                        |                                                               |                                                                                                 |                                                   |                                                                                                                            |  |  |  |
| 22. I certify that (1) this hospital attended the deceased from <b>10/31</b> 19 <b>77</b> to <b>9/26</b> 19 <b>82</b> , that (1) (we) last saw the deceased alive on <b>9/15/82</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) read (did not) saw the body after death. |  |                                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                          |                                                               |                                                                                                 |                                                   |                                                                                                                            |  |  |  |
| 22a. SIGNATURE<br><b>Dr. David A. Schwartz</b>                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                          |                                                               |                                                                                                 |                                                   | 22b. DATE SIGNED<br><b>9/28/82</b>                                                                                         |  |  |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. David A. Schwartz</b>                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                          |                                                               |                                                                                                 |                                                   | 22d. ADDRESS<br><b>7845 Oakwood Road<br/>Glen Burnie, Md. 21061</b>                                                        |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                 |  | 23b. DATE<br><b>October 2, 1982</b>                                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Forest Hill Cem.</b>                            |                                                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Memphis Shelby Tenn.</b>                       |                                                   |                                                                                                                            |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>R. H. Hopkins</b> ADDRESS <b>Singleton Funeral Home, Glen Burnie, Md.</b>                                                                                                                                                                                                                                                |  |                                                                                                                                                 |  |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 29 1982</b>                                      |                                                               | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                             |                                                   |                                                                                                                            |  |  |  |

September 26, 1962

ST. LOUIS, MO.

WILLIAM

WILLIAM

73

March 12, 1962

Miss

Miss

Miss

Miss

So. Baltimore General Hosp. Dept. Manager, Baltimore

7043 Myrtle Dr. Baltimore, Md.

John

John

John

John

John

John

John

John

John

John

John

John

417-22-4107 Mr. Newell O. Sprague, Jr. St. Louis, Mo.

Enclosed for you

Mr. William



Enclosed for you

7043 Myrtle Dr. Baltimore, Md.

Mr. David A. Schwartz

(Mid-town)

October 2, 1962

John

Shelby Tenn.

Forest Hill Co., Memphis

Enclosed for you

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                     |                          |                                                                                                                                          |  |                                                        |  |                                                                                                                                                             |                                                                                                                                                                  |                                              |  |                                                                                                                                                                                                                                                                           |  |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Exiemina (Eximena)</b>                                                                                                                                                                                                                                                                                                                                                                                              |  |                     | FIRST<br><b>Stafford</b> |                                                                                                                                          |  | LAST                                                   |  |                                                                                                                                                             | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br><input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR<br><b>9 9 19 82</b> |                                              |  | 2b. HOUR<br><b>10:15</b>                                                                                                                                                                                                                                                  |  |  |  |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br><b>B</b> |                          | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 4 05</b>                                                                                     |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>76</b> YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                                                                                                    |                                                                                                                                                                  | 7c. DATE PRONOUNCED DEAD<br><b>9 9 19 82</b> |  | 2d. HOUR<br><b>10:15</b>                                                                                                                                                                                                                                                  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  |                     |                          | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                            |  |                                                        |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                                  |                                              |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.                                                                                                                                                                                                        |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                     |                          | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1236 E. Preston St.</b> |  |                                                        |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                               |                                                                                                                                                                  |                                              |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                         |  |  |  |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                     |                          | 13b. COUNTY                                                                                                                              |  |                                                        |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                                                                                                                                                                  |                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                           |  |  |  |
| 13e. STREET ADDRESS<br><b>1236 E. Preston St.</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  |                     |                          | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James E. Anderson</b>                                                                       |  |                                                        |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Susan E. Robinson</b>                                                                                   |                                                                                                                                                                  |                                              |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                         |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                     |                          | 17. INFORMANT<br><b>Wilhelmina Roberts</b>                                                                                               |  |                                                        |  | ADDRESS<br><b>610 N. Walnut St. Wilmington, DE</b>                                                                                                          |                                                                                                                                                                  |                                              |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>4280</b> IMMEDIATE CAUSE (a) <b>Congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                                           |  |                     |                          |                                                                                                                                          |  |                                                        |  |                                                                                                                                                             |                                                                                                                                                                  |                                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                              |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                     |                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                        |  |                                                        |  |                                                                                                                                                             |                                                                                                                                                                  |                                              |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                       |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                     |  |                     |                          | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                        |  |                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |                                                                                                                                                                  |                                              |  |                                                                                                                                                                                                                                                                           |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                     |  |                     |                          | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                              |  |                                                        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                                                                                                  |                                              |  |                                                                                                                                                                                                                                                                           |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                     |                          |                                                                                                                                          |  |                                                        |  |                                                                                                                                                             |                                                                                                                                                                  |                                              |  |                                                                                                                                                                                                                                                                           |  |  |  |
| ACTUAL SIGNATURE<br><i>Thomas D. Smith</i>                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                     |                          | TITLE (SPECIFY)<br><b>M.D. Deputy Chief</b>                                                                                              |  |                                                        |  | DATE SIGNED<br><b>9/9/82</b>                                                                                                                                |                                                                                                                                                                  |                                              |  |                                                                                                                                                                                                                                                                           |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Thomas D. Smith, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |                     |                          | ADDRESS<br><b>111 Penn ST. Balto., MD.</b>                                                                                               |  |                                                        |  |                                                                                                                                                             |                                                                                                                                                                  |                                              |  |                                                                                                                                                                                                                                                                           |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  |                     |                          | 23b. DATE<br><b>9/16/82</b>                                                                                                              |  |                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>                                                                                                |                                                                                                                                                                  |                                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie MD</b>                                                                                                                                                                                                       |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  |                     |                          | ADDRESS<br><b>1101 E. North Ave.</b>                                                                                                     |  |                                                        |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 15 1982</b>                                                                                                         |                                                                                                                                                                  |                                              |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Connel</i>                                                                                                                                                                                                                       |  |  |  |

11-1-11

11-1-11

John G. ...



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 5 1 0

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                 |  |                                                                                                                                                      |                                                     |                                                                                                                                                             |                                       |                                                                                                 |  |
|-----------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Audrey J. Stanford</i>                              |  |                                                                                                                                                      | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>09 14 82</i> |                                                                                                                                                             | 2b. HOUR<br><i>10<sup>32</sup> AM</i> |                                                                                                 |  |
| 3. SEX<br><i>male</i>                                                                                           |  | 4. RACE<br><i>white</i>                                                                                                                              |                                                     | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>09 25 12</i>                                                                                                          |                                       | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br><i>69</i>                                                |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Tenn. TN</i>                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                                                                           |                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>South Baltimore General Hospital</i> |                                                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Shipyard worker</i>                                                                  |                                       | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>INDUSTRIAL</i>                                          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><i>MARYLAND</i> |  | 13b. COUNTY<br><i>BALTIMORE</i>                                                                                                                      |                                                     | 13c. CITY OR TOWN<br><i>BALTIMORE</i>                                                                                                                       |                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>John --- Stanford</i>                                                 |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Linda --- Bear</i>                                                                                  |                                                     | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i>                                               |                                       | 16b. SOCIAL SECURITY NO.<br><i>411-14-5878</i>                                                  |  |
|                                                                                                                 |  |                                                                                                                                                      |                                                     | 17. INFORMANT ADDRESS<br><i>Mrs. Audrey Ellingson, Same as above</i>                                                                                        |                                       |                                                                                                 |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Hemorrhagic shock*  
 4416  
 DUE TO, OR AS A CONSEQUENCE OF  
 (b) *Aorto-esophageal fistula*  
 DUE TO, OR AS A CONSEQUENCE OF  
 (c) *Aortic aneurysm*

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                     |  |                                                                                                                                                      |  |                                                                                                                               |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                 |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |  |                                                                                                                               |  |
| 22a. I certify that (this hospital) attended the deceased from <i>09-06</i> , 19 <i>82</i> , to <i>09-014</i> , 19 <i>82</i> , that (I) <input checked="" type="checkbox"/> lost<br>saw the deceased alive on <i>09-14</i> , 19 <i>82</i> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <input checked="" type="checkbox"/> (did <input type="checkbox"/> view the body after death. |  |                                                                     |  |                                                                                                                                                      |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><i>Steven Matson MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                     |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><i>Sept. 14</i>                                                                                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                     |  | 22e. ADDRESS                                                                                                                                         |  |                                                                                                                               |  |

|                                                                                                 |  |                                    |  |                                                               |  |                                                                         |  |
|-------------------------------------------------------------------------------------------------|--|------------------------------------|--|---------------------------------------------------------------|--|-------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <i>Burial</i>                                      |  | 23b. DATE<br><i>Sept. 17, 1982</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Cedar Hill Cemt.</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore Maryland</i> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>McCutty Funeral Home 130 E. Fort Ave. Balto. Md.</i> |  |                                    |  | 25a. DATE REC'D. BY REGISTRAR<br><i>SEP 15 1982</i>           |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Smith</i>                      |  |

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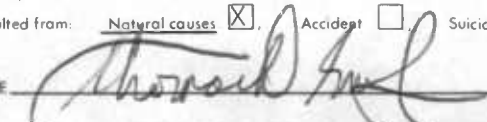
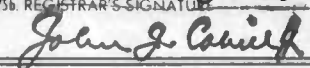
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 10 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                  |               |                                                                                                                                       |  |                                                 |  |                                                                                                                                                             |                 |                                                                          |  |                                                                                                                     |  |                                                                                     |                        |                                                |  |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------|---------------|---------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|--------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|------------------------|------------------------------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                      |  |                  | FIRST<br>Anna |                                                                                                                                       |  | MIDDLE<br>Mae                                   |  |                                                                                                                                                             | LAST<br>Stanton |                                                                          |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br><input checked="" type="checkbox"/> MONTH DAY YEAR<br>9 1 1982              |  |                                                                                     | 2b. HOUR<br>M<br>11:09 |                                                |  |  |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br>White |               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 30 00                                                                                         |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>82 YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                                                                                                    |                 | IF UNDER 24 HRS.                                                         |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>9 1 1982                                                              |  |                                                                                     | 2d. HOUR<br>M          |                                                |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Michigan                                                                                                                                                                                                                                                                                                                                                                                    |  |                  |               | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                |  |                                                 |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                 |                                                                          |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                                         |  |                                                                                     |                        |                                                |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                   |  |                  |               | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |  |                                                 |  |                                                                                                                                                             |                 | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired |  |                                                                                                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Housework                                      |                        |                                                |  |  |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                  |               | 13b. COUNTY<br>-----                                                                                                                  |  |                                                 |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |                 |                                                                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  |                                                                                     |                        | 13e. STREET ADDRESS<br>442 Elrino Street 21224 |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Philip Kelby                                                                                                                                                                                                                                                                                                                                                                                   |  |                  |               |                                                                                                                                       |  |                                                 |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Magdalene Murphy                                                                                      |                 |                                                                          |  |                                                                                                                     |  |                                                                                     |                        |                                                |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                              |  |                  |               | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>489-07-9919                                                                |  |                                                 |  | 17. INFORMANT<br>ADDRESS<br>Helen C. Kelby 442 Elrino Street 21224                                                                                          |                 |                                                                          |  |                                                                                                                     |  |                                                                                     |                        |                                                |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                                            |  |                  |               |                                                                                                                                       |  |                                                 |  |                                                                                                                                                             |                 |                                                                          |  |                                                                                                                     |  |                                                                                     |                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                      |  |                  |               |                                                                                                                                       |  |                                                 |  |                                                                                                                                                             |                 |                                                                          |  |                                                                                                                     |  |                                                                                     |                        |                                                |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                  |               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                     |  |                                                 |  |                                                                                                                                                             |                 |                                                                          |  |                                                                                                                     |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                        |                                                |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                   |  |                  |               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                            |  |                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |                 |                                                                          |  |                                                                                                                     |  |                                                                                     |                        |                                                |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                           |  |                  |               | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                           |  |                                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                 |                                                                          |  |                                                                                                                     |  |                                                                                     |                        |                                                |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |               |                                                                                                                                       |  |                                                 |  |                                                                                                                                                             |                 |                                                                          |  |                                                                                                                     |  |                                                                                     |                        |                                                |  |  |  |
| ACTUAL SIGNATURE<br>                                                                                                                                                                                                                                                                                                                                  |  |                  |               | TITLE (SPECIFY)<br>M.D. Deputy Chief                                                                                                  |  |                                                 |  | MEDICAL EXAMINER                                                                                                                                            |                 |                                                                          |  | DATE SIGNED<br>9/2/82                                                                                               |  |                                                                                     |                        |                                                |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Thomas D. Smith, M.D.                                                                                                                                                                                                                                                                                                                                                                              |  |                  |               | ADDRESS<br>111 Penn St. Balto., MD.                                                                                                   |  |                                                 |  |                                                                                                                                                             |                 |                                                                          |  |                                                                                                                     |  |                                                                                     |                        |                                                |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                   |  |                  |               | 23b. DATE<br>9-4-82                                                                                                                   |  |                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Our Lady of Good Counsel                                                                                              |                 |                                                                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Secretary Dorchester Co. Md.                                          |  |                                                                                     |                        |                                                |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>C.S. Zeiler & Son Inc.                                                                                                                                                                                                                                                                                                                                                                                   |  |                  |               | ADDRESS<br>6224 Eastern Avenue                                                                                                        |  |                                                 |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 3 1982                                                                                                                 |                 |                                                                          |  | 25b. REGISTRAR'S SIGNATURE<br> |  |                                                                                     |                        |                                                |  |  |  |

CLON BEP

C. J. Fisher & Son, Inc. 625 Madison Avenue  
New York 17, N.Y.  
9-4-52 The City of New Council Secretary, Rochester, N.Y.

to \_\_\_\_\_  
Miss Kelly  
487-7-919 Helen C. Kelly 412 Clinton Street 21334  
Baltimore  
X 412 Clinton Street 21334

Michigan U.S.A.  
Female White 2 30 00 25  
1911 1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to examine the body.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                              |  | 8 2 2 3 5 1 2<br>REG. NO.                                                                                                                                              |  |                                                                                                                                       |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Myrtle Staples</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 9 82</b>                                                                                                                   |  |                                                                                                                                       |  |
| 1. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br><b>Black</b>                                                                                                                      |  | 3. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 2 18</b>                                                                                                                    |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                      |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD</b>                                                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1910 W. Lexington Street</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                                       |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                     |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                              |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |  | 13d. STREET ADDRESS<br><b>1910 W. Lexington Street</b>                                                                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward Stapes</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Alice Cammett</b>                                                                        |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                          |  |                                                                                                                                       |  |
| 16b. SOCIAL SECURITY NO.<br><b>212-12-9507</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 17. INFORMANT<br>ADDRESS<br><b>Gwendolyn Hayes 1910 W. Lexington St.</b>                                                                     |  |                                                                                                                                                                        |  |                                                                                                                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>2500 DUE TO, OR AS A RESULT OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Atherosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pericardial Myofibrosis</b><br>APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b><br><b>5 years</b><br><b>10 years</b> |  |                                                                                                                                              |  |                                                                                                                                                                        |  |                                                                                                                                       |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>e</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |  |                                                                                                                                                                        |  |                                                                                                                                       |  |
| 19a. DATE OF OPERATION<br><b>NA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>NA</b>                                                                                                                                                                                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>NA NA NA</b>                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>NA</b>                                                                            |  |                                                                                                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.)                                                                            |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                      |  |                                                                                                                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/30</b> , 19 <b>82</b> , to <b>9/9</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>8/30</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.                                                                                                                                                                                            |  |                                                                                                                                              |  |                                                                                                                                                                        |  |                                                                                                                                       |  |
| 22b. SIGNATURE<br><b>Paul D. Light MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | DEGREE<br><b>MD</b>                                                                                                                          |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>9/14/82</b>                                                                                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PAUL D. LIGHT MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 22e. ADDRESS<br><b>U. of Md. Hospital</b>                                                                                                    |  |                                                                                                                                                                        |  |                                                                                                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br><b>9/13/82</b>                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>                                                                                                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus, Md.</b>                                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. Marhh F/H 1101 E. North Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 15 1982</b>                                                                                                                    |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canick</b>                                                                                   |  |

SEP 12 1983

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 5 1 3

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                    |                                                                                      |                                                                                                                                                             |                                                                  |                                                                                                                                            |                                                                                      |                                                                                     |                                                                                                                            |                                                                |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Audrey P. Steckel</b>                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                    | 2a. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>3</b> YEAR <b>82</b>                      |                                                                                                                                                             |                                                                  | 2b. HOUR<br><b>630A</b>                                                                                                                    |                                                                                      |                                                                                     |                                                                                                                            |                                                                |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br><b>Cauc</b>                                                                                                             |                                                                                      | 5. DATE OF BIRTH<br>MONTH <b>11</b> DAY <b>04</b> YEAR <b>19</b>                                                                                            |                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.                                                                                          |                                                                                      | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                                      |                                                                                                                            | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                         |                                                                                      | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY Balt</b> MD.                                                                               |                                                                                      |                                                                                     |                                                                                                                            |                                                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERCY HOSPITAL</b> |                                                                                      |                                                                                                                                                             |                                                                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOME MAKER</b>                                                      |                                                                                      |                                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                                |  |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                    |  | 13b. COUNTY<br><b>BALTIMORE</b>                                                                                                    |                                                                                      | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                       |                                                                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                            |                                                                                      | 13e. STREET ADDRESS<br><b>1323 CAMBRIA ST.</b>                                      |                                                                                                                            |                                                                |  |
| 14. FATHER'S NAME<br>FIRST <b>JOSEPH</b> MIDDLE <b>John</b> LAST <b>MURDOCK</b>                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                    |                                                                                      |                                                                                                                                                             |                                                                  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ESTELLE</b> MIDDLE <b>-</b> LAST <b>SCHULHAUSE</b>                                                    |                                                                                      |                                                                                     |                                                                                                                            |                                                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                    |                                                                                      | 16b. SOCIAL SECURITY NO.<br><b>Unknown</b>                                                                                                                  |                                                                  | 17. INFORMANT<br>ADDRESS<br><b>Mr. Ralph Steckel, Same as above</b>                                                                        |                                                                                      |                                                                                     |                                                                                                                            |                                                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br><b>4960</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC Obstructive Pulmonary Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>YEARS</b> |  |                                                                                                                                    |                                                                                      |                                                                                                                                                             |                                                                  |                                                                                                                                            |                                                                                      |                                                                                     |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MINUTES</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>MORBID OBESITY</b>                                                                                                                                                                                                                                                     |  |                                                                                                                                    |                                                                                      |                                                                                                                                                             |                                                                  |                                                                                                                                            |                                                                                      |                                                                                     |                                                                                                                            |                                                                |  |
| 19a. DATE OF OPERATION<br><b>8-23-82</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>PERFORATED Duodenal Ulcer</b> |                                                                                                                                                             |                                                                  |                                                                                                                                            | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                          |  |                                                                                                                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                    |                                                                                                                                                             |                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                             |                                                                                      |                                                                                     |                                                                                                                            |                                                                |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                    | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)               |                                                                                                                                                             |                                                                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                                      |                                                                                     |                                                                                                                            |                                                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/23</b> , 19 <b>82</b> , to <b>9/3</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>9/3</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did) (did not) view the body after death.                                                   |  |                                                                                                                                    |                                                                                      |                                                                                                                                                             |                                                                  |                                                                                                                                            |                                                                                      |                                                                                     |                                                                                                                            |                                                                |  |
| 22b. SIGNATURE<br><b>Michael Rossini Jr MD</b> DEGREE                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                    |                                                                                      |                                                                                                                                                             |                                                                  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                      |                                                                                     | 22c. DATE SIGNED<br><b>9/3/82</b>                                                                                          |                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MICHAEL ROSSINI JR MD</b>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                    |                                                                                      |                                                                                                                                                             |                                                                  | 22e. ADDRESS<br><b>MERCY HOSPITAL</b>                                                                                                      |                                                                                      |                                                                                     |                                                                                                                            |                                                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                    | 23b. DATE<br><b>Sept. 7, 1982</b>                                                    |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cemetery</b> |                                                                                                                                            |                                                                                      | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE <b></b> |                                                                                                                            |                                                                |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>McCully Funeral Home</b> ADDRESS <b>237 E. Patapsco Ave. Balto.</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                    |                                                                                      |                                                                                                                                                             |                                                                  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 3 1982</b>                                                                                         |                                                                                      |                                                                                     | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canine</b>                                                                        |                                                                |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                        |  |                  |                                                                                                                                        |                                                             |                                                           |                                                                                                                                                             |                                                                                      |                                                                      |                                                             | REG. NO. 2 3 5 1 4                                                                  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Mary E. Steele                                                                                                                                                                                                                                                                                                                                                                        |  |                  |                                                                                                                                        |                                                             |                                                           | 2a. DATE KNOWN OF DEATH<br>XX MONTH DAY YEAR<br>9 26 19 82                                                                                                  |                                                                                      | 2b. HOUR<br>M<br>11:43 a. M                                          |                                                             |                                                                                     |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br>White |                                                                                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 23 42               |                                                           | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br>40 YRS.                                                                                      |                                                                                      | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>9 26 19 82             |                                                             | 7d. HOUR<br>a. M                                                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                          |  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                    |                                                             |                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                      |                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD. |                                                                                     |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                         |  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>791 Carroll Street 21230 |                                                             |                                                           |                                                                                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                        |                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY                           |                                                                                     |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                  | 13b. COUNTY<br>--                                                                                                                      |                                                             | 13c. CITY OR TOWN<br>Baltimore                            |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                      | 13e. STREET ADDRESS<br>791 Carroll Street 21230             |                                                                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Samuel Scotten                                                                                                                                                                                                                                                                                                                                                                                       |  |                  |                                                                                                                                        |                                                             |                                                           | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ida Elizabeth Johnson                                                                                      |                                                                                      |                                                                      |                                                             |                                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                    |  |                  |                                                                                                                                        | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)     |                                                           | 17. INFORMANT ADDRESS<br>Mrs. Shirley Reed 804 Stewart Ave. 21061                                                                                           |                                                                                      |                                                                      |                                                             |                                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease<br>4029<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                                                                     |  |                  |                                                                                                                                        |                                                             |                                                           |                                                                                                                                                             |                                                                                      |                                                                      |                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                            |  |                  |                                                                                                                                        |                                                             |                                                           |                                                                                                                                                             |                                                                                      |                                                                      |                                                             |                                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                  |                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                                                           |                                                                                                                                                             |                                                                                      |                                                                      |                                                             | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                         |  |                  |                                                                                                                                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |                                                                                      |                                                                      |                                                             |                                                                                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                 |  |                  |                                                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                                                           | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                      |                                                                      |                                                             |                                                                                     |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |                                                                                                                                        |                                                             |                                                           |                                                                                                                                                             |                                                                                      |                                                                      |                                                             |                                                                                     |  |
| ACTUAL SIGNATURE<br>Dennis F. Smyth, M.D.                                                                                                                                                                                                                                                                                                                                                                                                      |  |                  |                                                                                                                                        |                                                             |                                                           | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER                                                                                                               |                                                                                      |                                                                      | DATE SIGNED<br>9-27-82                                      |                                                                                     |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Dennis F. Smyth, M.D.                                                                                                                                                                                                                                                                                                                                                                                    |  |                  |                                                                                                                                        | ADDRESS<br>111 Penn Street                                  |                                                           |                                                                                                                                                             |                                                                                      |                                                                      |                                                             |                                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                         |  |                  | 23b. DATE<br>9/29/82                                                                                                                   |                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery |                                                                                                                                                             |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brooklyn Park Maryland |                                                             |                                                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>A. Alan Seitz Funeral Home                                                                                                                                                                                                                                                                                                                                                                                     |  |                  |                                                                                                                                        |                                                             |                                                           | ADDRESS<br>3818 Roland Ave                                                                                                                                  |                                                                                      |                                                                      | 25a. DATE REC'D. BY REGISTRAR<br>SEP 30 1982                |                                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                  |                                                                                                                                        |                                                             |                                                           | 25b. REGISTRAR'S SIGNATURE<br>Joan J. Connel                                                                                                                |                                                                                      |                                                                      |                                                             |                                                                                     |  |



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

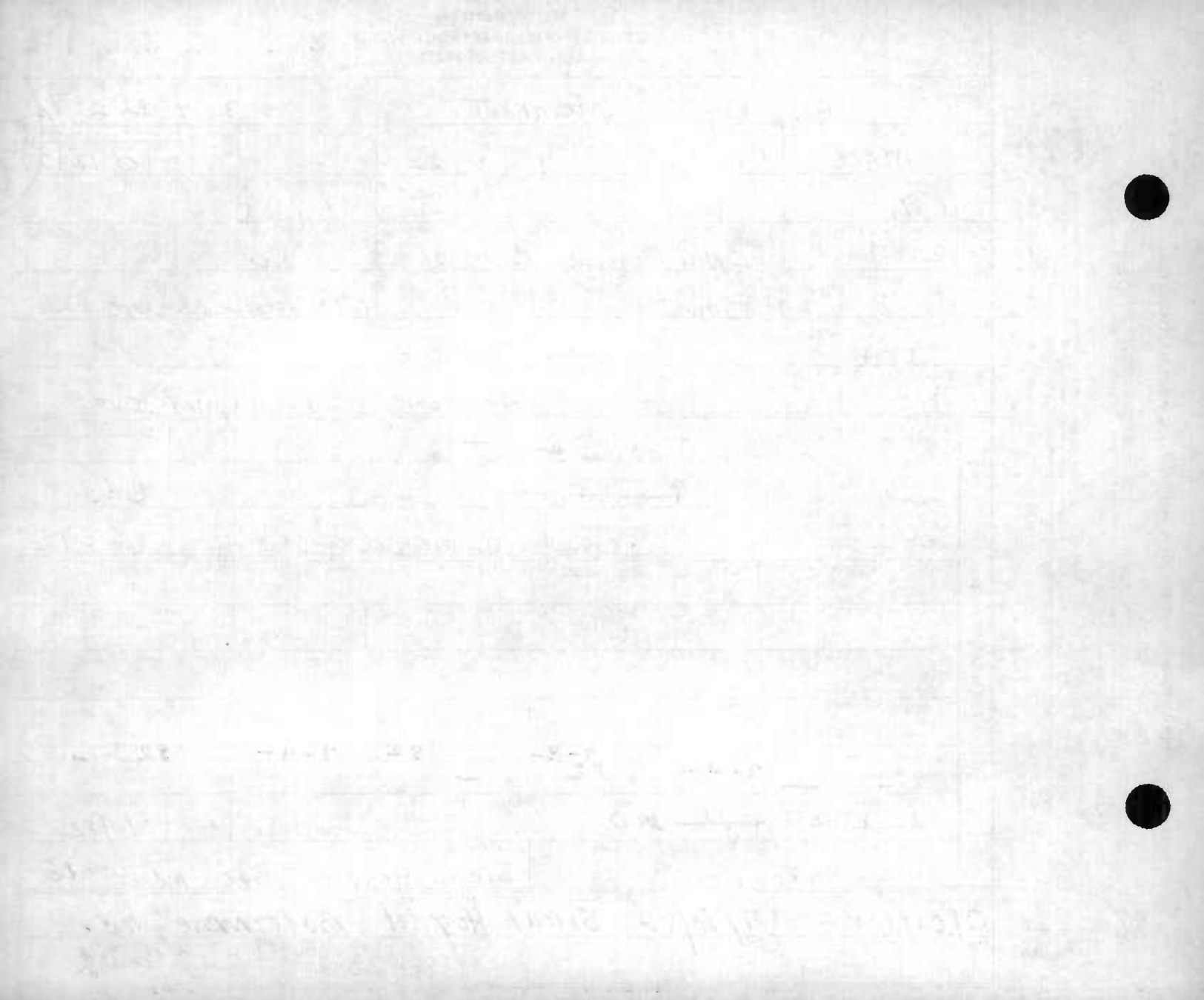
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REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                          |                                                                        |                                                                                                                                                             |                                                             |                                                                                                                                                             |                                                                                                 |                                                                                                                            |                                                           |                                              |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Baby Boy Steinhart</b>                                                                                                                                                                                                                                                                         |  |                                                                                                                                          | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>7 4 82</b>                   |                                                                                                                                                             |                                                             | 2b. HOUR<br><b>2:57 A.M.</b>                                                                                                                                |                                                                                                 |                                                                                                                            |                                                           |                                              |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br><b>Cauc</b>                                                                                                                   |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 3 82</b>                                                                                                         |                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br><b>0 0 12 27</b>                                                                                      |                                                                                                 | IF UNDER 1 YEAR<br>IF UNDER 24 HRS.                                                                                        |                                                           |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>USA</b>                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                               |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALto City</b> MD.                                                                                               |                                                                                                 |                                                                                                                            |                                                           |                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALto City</b>                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital BALto</b> |                                                                        |                                                                                                                                                             |                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NB</b>                                                                               |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                           |                                              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>                                                                                                                                                                                                                  |  |                                                                                                                                          |                                                                        |                                                                                                                                                             | 13b. CITY OR TOWN<br><b>BALto City</b>                      |                                                                                                                                                             | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13d. STREET ADDRESS<br><b>6711 Park Heights Ave BALto</b> |                                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>IRA Steinhart</b>                                                                                                                                                                                                                                                                           |  |                                                                                                                                          | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Debbie</b>         |                                                                                                                                                             |                                                             | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                                               |                                                                                                 |                                                                                                                            |                                                           | 16b. SOCIAL SECURITY NO.                     |  |
| 17. INFORMANT<br><b>Linda Henn</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                          | 18. ADDRESS<br><b>Sinai Hospital, Inc</b>                              |                                                                                                                                                             |                                                             | 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br><b>7650 IMMEDIATE CAUSE (a) Cardiac Arrest</b> |                                                                                                 |                                                                                                                            |                                                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                                           |  |                                                                                                                                          | DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Prematurity Hypoxia</b>       |                                                                                                                                                             |                                                             | DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Prematurity 26wks gestation</b>                                                                                    |                                                                                                 |                                                                                                                            | 6hrs<br>6hr 27 min                                        |                                              |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                      |  |                                                                                                                                          |                                                                        |                                                                                                                                                             |                                                             |                                                                                                                                                             |                                                                                                 |                                                                                                                            |                                                           |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                           |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                  |  |                                                                                                                                          | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |                                                                                                                                                             |                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                                 |                                                                                                                            |                                                           |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                             |  |                                                                                                                                          | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                                 |                                                                                                                            |                                                           |                                              |  |
| 22a. I certify that (this hospital) attended the deceased from <b>7-3-</b> 19 <b>82</b> , to <b>7-4-</b> 19 <b>82</b> , that (we) last saw the deceased alive on <b>7-4-</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (view) the body after death. |  |                                                                                                                                          |                                                                        |                                                                                                                                                             |                                                             |                                                                                                                                                             |                                                                                                 |                                                                                                                            |                                                           |                                              |  |
| 22b. SIGNATURE<br><b>Andri B. Grozden M.D.</b>                                                                                                                                                                                                                                                                                           |  |                                                                                                                                          | DEGREE                                                                 |                                                                                                                                                             |                                                             | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |                                                                                                 |                                                                                                                            | 22c. DATE SIGNED<br><b>7/4/82</b>                         |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Andri Grozden</b>                                                                                                                                                                                                                                                                            |  |                                                                                                                                          | 22e. ADDRESS<br><b>Sinai Hospital BALto MD 21225</b>                   |                                                                                                                                                             |                                                             |                                                                                                                                                             |                                                                                                 |                                                                                                                            |                                                           |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(ICR)<br><b>CREATION</b>                                                                                                                                                                                                                                                                              |  |                                                                                                                                          | 23b. DATE<br><b>7/10/82</b>                                            |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sinai Hospital</b> |                                                                                                                                                             | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                             |                                                                                                                            |                                                           |                                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>BP</b>                                                                                                                                                                                                                                                                                                |  |                                                                                                                                          | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 23 1982</b>                    |                                                                                                                                                             |                                                             | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>                                                                                                         |                                                                                                 |                                                                                                                            |                                                           |                                              |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                            |  | REG. NO. 8 2 2 3 5 1 6                                                                                                                                         |  |                                                                                      |  |                                                                                                                                       |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MELISSA STERLING</b>                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                            |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>SEPTEMBER 9, 1982</b>                                                                                                   |  |                                                                                      |  | 2b. HOUR<br><b>3:05aM</b>                                                                                                             |  |
| 3 SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>BLACK</b>                                                                                                                    |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 21 27</b>                                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.                                                                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |                                                                                                                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |                                                                                                                                                                |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                     |  |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY                                                                                                                                |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>606 McCade Avenue</b>                                                                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>EDWARD KELLY</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                            |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELIZABETH PERRY</b>                                                                                        |  |                                                                                      |  |                                                                                                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                                                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.                                                                                                                   |  | 17. INFORMANT ADDRESS<br><b>JOAN STERLING 5511 Kennison Ave., Balto, Md.</b>                                                                                   |  |                                                                                      |  |                                                                                                                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1369 Asystole</b><br>IMMEDIATE CAUSE (a) <b>Asystole</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Multiple metabolic disorders</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>infection, bleeding</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |                                                                                                                                            |  |                                                                                                                                                                |  |                                                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs</b><br><b>3 days</b>                                                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>AML</b>                                                                                                                                                                                                                                                                     |  |                                                                                                                                            |  |                                                                                                                                                                |  |                                                                                      |  |                                                                                                                                       |  |
| 19a. DATE OF OPERATION<br><b>—</b>                                                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                           |  |                                                                                                                                                                |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                                  |  |                                                                                      |  |                                                                                                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                     |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                      |  |                                                                                                                                       |  |
| 22a. I certify that (I) this hospital attended the deceased from <b>8-28</b> , 19 <b>82</b> , to <b>9-9</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>9-9</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) did (did not) view the body after death.                                                               |  |                                                                                                                                            |  |                                                                                                                                                                |  |                                                                                      |  |                                                                                                                                       |  |
| 22b. SIGNATURE<br><b>William A. Domkowski</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                            |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                                                                                      |  | 22c. DATE SIGNED<br><b>9-9-82</b>                                                                                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WILLIAM A DOMKOWSKI</b>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                            |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>                                                                                                                  |  |                                                                                      |  |                                                                                                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br><b>9-14-1982</b>                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>NEW PINE GROVE CEME.</b>                                                                                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Waterbury Conn.</b>                 |  |                                                                                                                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                            |  | 24a. ADDRESS<br><b>Annapolis, Md.</b>                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 10 1982</b>                                  |  |                                                                                                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                            |  |                                                                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Lamer</b>                                   |  |                                                                                                                                       |  |

2711 BP

UNITED STATES  
DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C.

RECEIVED

NOV 19 1917

UNITED STATES DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE



NOV 19 1917



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 5 1 7

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                        |                                                                        |                                                                                                                                                             |                                                                                       |                                                                                      |                                                   |                                                                                                                            |                                                                                              |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HATTIE R. STEVENSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                        | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Sept. 6, 1982</b>               |                                                                                                                                                             |                                                                                       | 2b. HOUR<br><b>M</b>                                                                 |                                                   |                                                                                                                            |                                                                                              |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br><b>NEGROID</b>                                                                                                              |                                                                        | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>NOV. 19, 1892</b>                                                                                                     |                                                                                       | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN<br><b>89</b> YRS               |                                                   | IF UNDER 1 YEAR IF UNDER 24 HRS                                                                                            |                                                                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                          |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.                       |                                                   |                                                                                                                            |                                                                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1303 N. Dallas St.</b> |                                                                        |                                                                                                                                                             |                                                                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>housewife</b> |                                                   | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                                                              |  |
| 13a. STATE<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                        |                                                                        |                                                                                                                                                             | 13b. COUNTY                                                                           |                                                                                      | 13c. CITY OR TOWN<br><b>Balto.</b>                |                                                                                                                            | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>GEORGE JONES</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                        |                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>MARGARET BANTON</b>                  |                                                                                      |                                                   |                                                                                                                            |                                                                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                        | 16b. SOCIAL SECURITY NO.<br><b>216-10-9781</b>                         |                                                                                                                                                             | 17. INFORMANT<br><b>Mildred Duarte</b>                                                |                                                                                      |                                                   | ADDRESS<br><b>1300 E. Danville Apt 803</b>                                                                                 |                                                                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Severe Anorexia</b><br><b>4571</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>marked Elephantiasis-</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>marked Venous obstruction of legs</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 month</b><br><b>10+ years</b><br><b>50+ yrs-</b> |  |                                                                                                                                        |                                                                        |                                                                                                                                                             |                                                                                       |                                                                                      |                                                   |                                                                                                                            |                                                                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                        |                                                                        |                                                                                                                                                             |                                                                                       |                                                                                      |                                                   |                                                                                                                            |                                                                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                        | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                |                                                                                                                                                             |                                                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                   |                                                                                                                            |                                                                                              |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                                       | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE                                           |                                                   |                                                                                                                            |                                                                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6</b> , 19 <b>82</b> , to <b>9-6-</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>8-23</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                         |  |                                                                                                                                        |                                                                        |                                                                                                                                                             |                                                                                       |                                                                                      |                                                   |                                                                                                                            |                                                                                              |  |
| 22b. SIGNATURE<br><b>Eugene H. Owens MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                        |                                                                        |                                                                                                                                                             |                                                                                       | DEGREE<br><b>MD</b>                                                                  |                                                   | 22c. DATE SIGNED<br><b>9-9-82</b>                                                                                          |                                                                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>EUGENE OWENS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                        |                                                                        |                                                                                                                                                             |                                                                                       | 22e. ADDRESS<br><b>1735 E. Federal St.</b>                                           |                                                   |                                                                                                                            |                                                                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                        | 23b. DATE<br><b>9-10-82</b>                                            |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cem. Anne Arundel County, MD</b> |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE        |                                                                                                                            |                                                                                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Calvin B. Scruggs</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                        |                                                                        |                                                                                                                                                             | ADDRESS<br><b>1412 E. Preston St</b>                                                  |                                                                                      | 25. DATE REC'D. BY REGISTRAR<br><b>SEP 9 1982</b> |                                                                                                                            | 26. REGISTRAR'S SIGNATURE<br><b>John J. Carter</b>                                           |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

RECEIVED OCT 20 2002

UNITED STATES

UNITED STATES

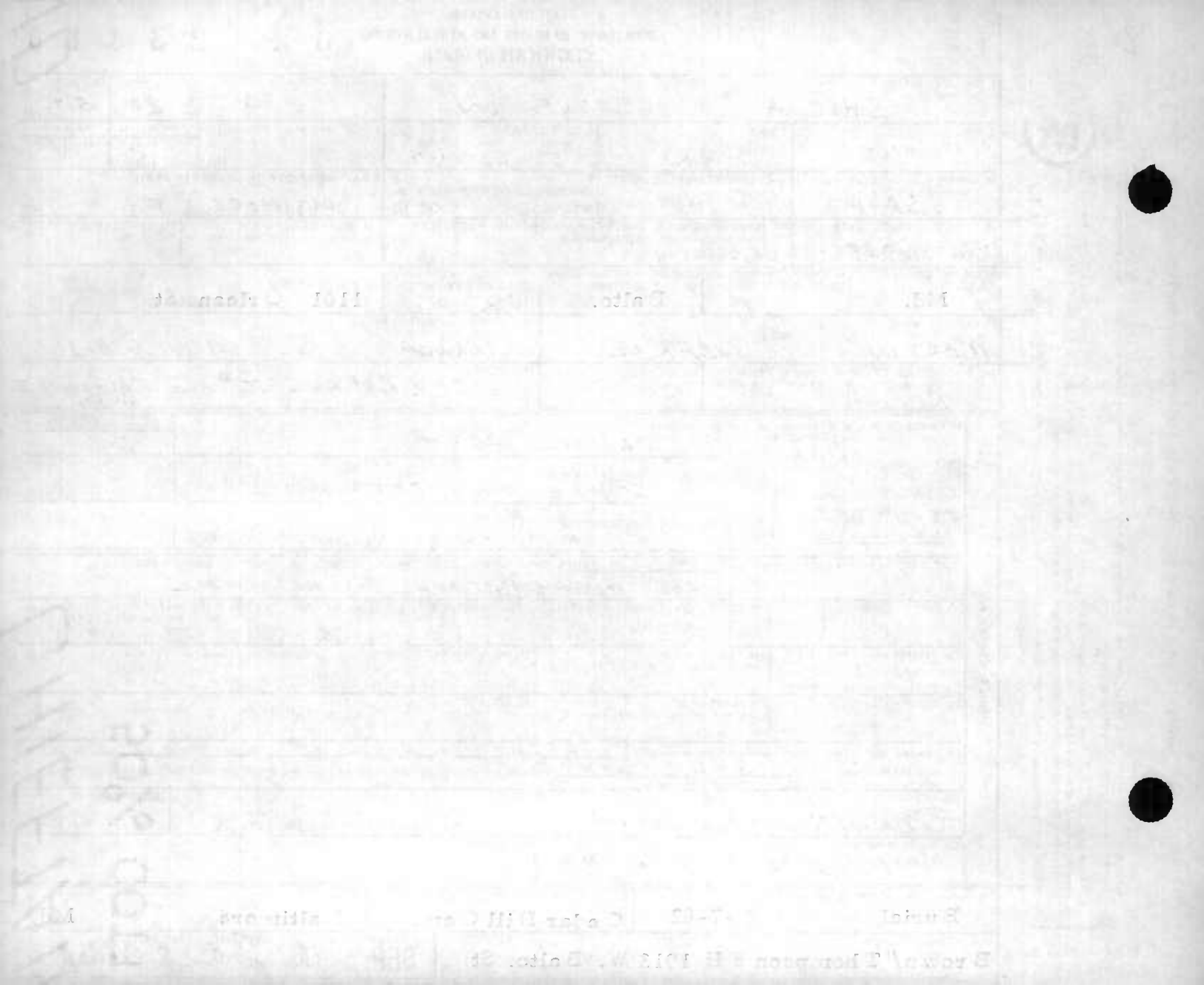
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                            |  |                                                                                                                         |  | REG. NO. 8 2 1 2 3 5 1 8                                                                                                                                    |  |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                         |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                                            |  |                                                                                                                            |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>SHEENA STEVENSON                                                                                                                                                                                                                                                                                          |  |                                                                                                                         |  | 2b. HOUR<br>5:40 P <sup>M</sup>                                                                                                                             |  |                                                                                                                            |  |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br>BLACK                                                                                                        |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>5 28 82                                                                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. 35                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>USA-MD.                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                     |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIVERSITY |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Md. 13b. COUNTY BALTO. 13c. CITY OR TOWN Balto.                                                                                                                                                                                      |  |                                                                                                                         |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  |                                                                                                                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>MARTIN BARNES                                                                                                                                                                                                                                                                                            |  |                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>WANDA L. STEVENSON                                                                                            |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.                                                                                                |  | 17. INFORMANT ADDRESS<br>1101 ORLEANS ST. #26 BALTIMORE MD.                                                                                                 |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>7651 IMMEDIATE CAUSE (a) CARDIAC ARREST<br>DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE CNS DETERIORATION<br>DUE TO, OR AS A CONSEQUENCE OF (c) PREMATUREITY AND RESPIRATORY DISTRESS<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>BRONCHO PULMONARY DYSPLASIA, SEIZURE DISORDER                                                                                                                                                             |  |                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                        |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-28, 1982, to 9-2, 1982, that (I) (we) last saw the deceased alive on 9-2, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                   |  |                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>Mary Lenore Kesler MD.                                                                                                                                                                                                                                                                                                        |  |                                                                                                                         |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>9-2-82                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARY LENORE KESLER MD.                                                                                                                                                                                                                                                                                 |  |                                                                                                                         |  | 22e. ADDRESS                                                                                                                                                |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br>9-7-82                                                                                                     |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cem.                                                                                                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                                                                |  |
| 24. FUNERAL DIRECTOR<br>NAME BROWN/ THOMPSON FH 1913 W. Balto. St.                                                                                                                                                                                                                                                                              |  |                                                                                                                         |  | 25a. DATE REC'D. BY REGISTRAR IN REGISTRAR'S SIGNATURE<br>SEP 7 1982 John J. Carver                                                                         |  |                                                                                                                            |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a copy of the report filed with this certificate.

## MEDICAL CERTIFICATION

| Item 13a-e&14 \$15<br>FOR 1 - STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                          |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                     |  | 8 2 2 3 5 1 9<br>REG. NO.                                                                                                                  |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>BABY GIRL STEWART                                                                                                                                                                                                                                                                                                             |  |                                                                                                                          |  | 20. DATE OF DEATH MONTH DAY YEAR<br>7 19 82                                                                                                              |  | 2b. HOUR<br>8:20 AM                                                                                                                        |                                              |
| 3. SEX<br>female                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br>CAUC                                                                                                          |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>7 19 82                                                                                                               |  | 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS.<br>2 hrs 20 min YRS. MONTHS DAYS HOURS MIN.                               |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                      |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                                 |                                              |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>N/A                                                                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>N/A                                                                                                   |                                              |
| 13a. STATE<br>Md                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                          |  | 13b. COUNTY<br>Baltimore                                                                                                                                 |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                             |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Herbert                                                                                                                                                                                                                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Terresa Stanart                                                            |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  |                                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.                                                                                                 |  | 17. INFORMANT ADDRESS<br>4213 N. Rogens Ave. 21215                                                                                                       |  |                                                                                                                                            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 7650 Prematurity 22 wk gestation Cardio pulmonary immaturity<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |                                                                                                                          |  |                                                                                                                                                          |  |                                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                                   |  |                                                                                                                          |  |                                                                                                                                                          |  |                                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                         |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                    |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                           |  |                                                                                                                                            |                                              |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                      |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                                            |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/19/82 to 7/19/82, that (I) (we) last saw the deceased alive on 7/19/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.                                                                                  |  |                                                                                                                          |  |                                                                                                                                                          |  |                                                                                                                                            |                                              |
| 22b. SIGNATURE<br>Michael Douso MD                                                                                                                                                                                                                                                                                                                                                     |  | DEGREE                                                                                                                   |  | 22c. DATE SIGNED<br>7/19/82                                                                                                                              |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MICHAEL DOUSO MD.                                                                                                                                                                                                                                                                                                                             |  | 22e. ADDRESS<br>SINAI HOSPITAL, BALTIMORE MD 21215                                                                       |  |                                                                                                                                                          |  |                                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (S, IF)<br>CREATION                                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br>7/25/82                                                                                                     |  | 23c. NAME OF CEMETERY OR CREMATORY<br>SINAI Hospital                                                                                                     |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Md.                                                                                  |                                              |
| 24. FUNERAL DIRECTOR NAME<br>BP                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 23 1982                                                                                                             |  |                                                                                                                                            |                                              |
| ADDRESS                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                          |  | REGISTRAR'S SIGNATURE<br>John J. Carver                                                                                                                  |  |                                                                                                                                            |                                              |



Items #18a-22a Film G572 10/26/82 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8 2 2 3 5 2 0

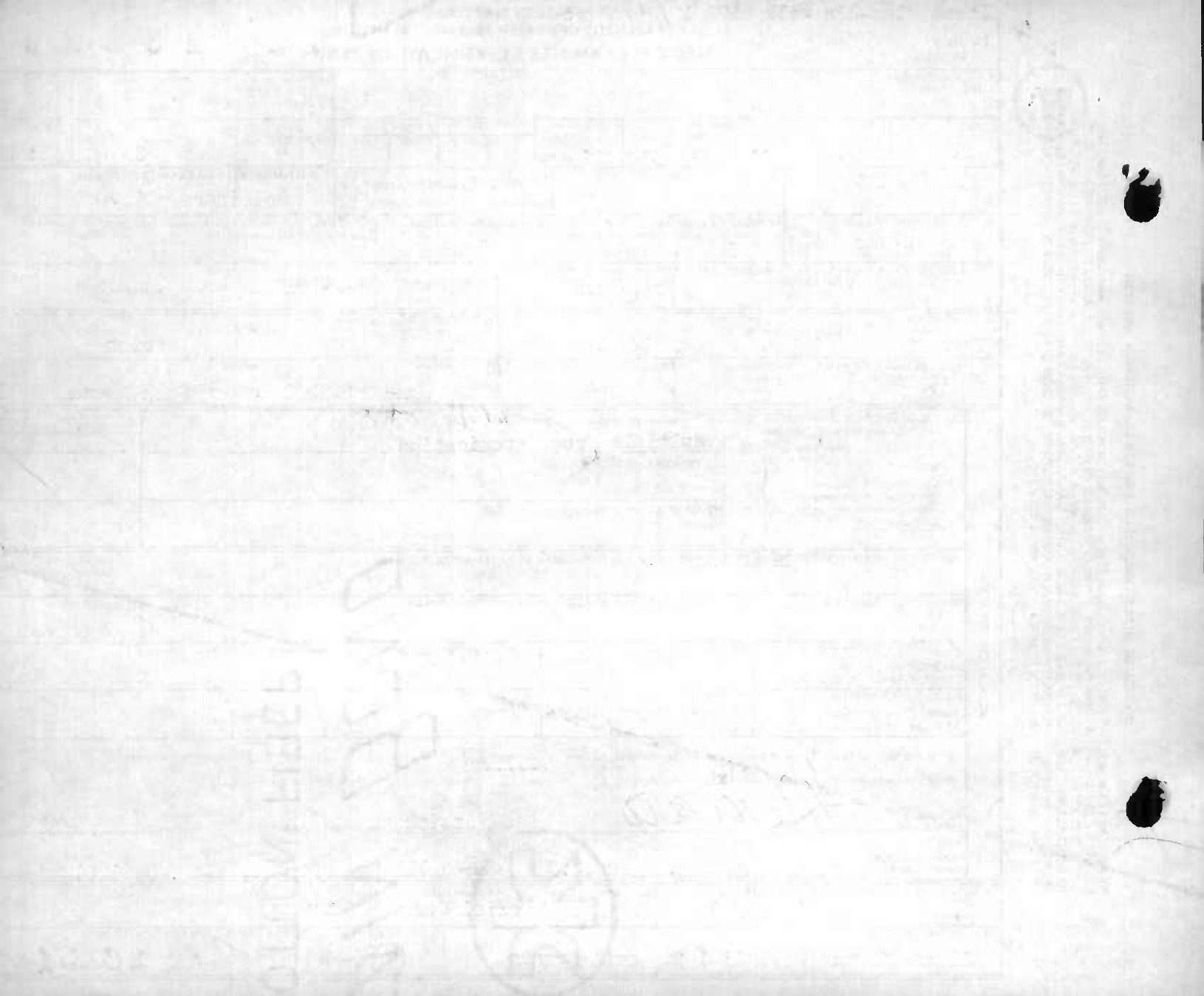
|                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                         |  |                                                                                                                                       |  |                                                                    |  |                                                                                                                                                             |  |                                                                                                          |  |                                                                                     |  |                                   |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Anthony Keith Stewart</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |                         |  |                                                                                                                                       |  |                                                                    |  |                                                                                                                                                             |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>9 3 19 82</b> |  | 2b. HOUR<br>M <b>6:57A</b>                                                          |  |                                   |  |
| 3. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br><b>black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>11 23 55</b>                                                                                    |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS. <b>26</b>                  |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                                                                                                    |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>9 3 19 82</b>                                              |  | 7d. HOUR<br>M <b>6:57A</b>                                                          |  |                                   |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                            |  |                                                                    |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                                                          |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                       |  | MD                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3000 Howard Park</b> |  |                                                                    |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                            |  |                                                                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                         |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                       |  |                                                                    |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |  | 13e. STREET ADDRESS<br><b>3203 Howard Park Avenue</b>                               |  |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Kenneth J. Stewart</b>                                                                                                                                                                                                                                                                                                                                                                                   |  |                         |  |                                                                                                                                       |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ruth Price</b> |  |                                                                                                                                                             |  |                                                                                                          |  |                                                                                     |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                    |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>                                                                                                |  |                                                                    |  | 17. INFORMANT<br>ADDRESS<br><b>Ruth Stewart 3203 Howard Park Avenue</b>                                                                                     |  |                                                                                                          |  |                                                                                     |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>3049</b> IMMEDIATE CAUSE (a) <b>Multiple drug intoxication</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                          |  |                         |  |                                                                                                                                       |  |                                                                    |  |                                                                                                                                                             |  |                                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                        |  |                                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).                                                                                                                                                                                                                                                                                                                   |  |                         |  |                                                                                                                                       |  |                                                                    |  |                                                                                                                                                             |  |                                                                                                          |  |                                                                                     |  |                                   |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                     |  |                                                                    |  |                                                                                                                                                             |  |                                                                                                          |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                            |  |                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                               |  |                                                                                                          |  |                                                                                     |  |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                             |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                           |  |                                                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                          |  |                                                                                     |  |                                   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |                                                                                                                                       |  |                                                                    |  |                                                                                                                                                             |  |                                                                                                          |  |                                                                                     |  |                                   |  |
| ACTUAL SIGNATURE<br><b>H. Guard</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                         |  | M.D. <b>Assistant</b> MEDICAL EXAMINER                                                                                                |  |                                                                    |  | DATE SIGNED <b>9/3/82</b>                                                                                                                                   |  |                                                                                                          |  |                                                                                     |  |                                   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Hormez R. Guard, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                    |  |                         |  | ADDRESS <b>111 Penn Street, Balto MD 21201</b>                                                                                        |  |                                                                    |  |                                                                                                                                                             |  |                                                                                                          |  |                                                                                     |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                         |  |                         |  | 23b. DATE<br><b>9/8/82</b>                                                                                                            |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Park</b> |  |                                                                                                                                                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus MD</b>                                          |  |                                                                                     |  |                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William C. March F/H 1101 E. North Avenue</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                         |  |                                                                                                                                       |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 8 1982</b>                 |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                                                                                         |  |                                                                                                          |  |                                                                                     |  |                                   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP 2802  
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                  |  | 8 2 2 3 5 2 1                                                                                                                                               |  |                                                                                                                         |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                  |  | REG. NO.                                                                                                                                                    |  |                                                                                                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM STOKER SR.</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                  |  | 2a. DATE OF DEATH MONTH <b>09</b> DAY <b>03</b> YEAR <b>82</b>                                                                                              |  | 2b. HOUR <b>1:43pm</b>                                                                                                  |  |
| 1. SEX <b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE <b>White</b>                                                                                                             |  | 5. DATE OF BIRTH MONTH <b>9</b> DAY <b>18</b> YEAR <b>10</b>                                                                                                |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.                                                                          |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                          |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.                                                          |  |
| 10. CITY OR TOWN OF DEATH <b>BALTO., CITY</b>                                                                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sales Manager</b>                                                                          |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Trucking-Retiree</b>                                                               |  |
| 13a. STATE <b>Md</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Catonsville</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                           |  | 13e. STREET ADDRESS <b>411 Chalfonte Drive</b>                                                                          |  |
| 14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>J.</b> LAST <b>Stoker</b>                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Marie</b> MIDDLE <b>Schilling</b> LAST <b>Schilling</b>                                                                   |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                  |  | 16b. SOCIAL SECURITY NO. <b>215-07-3290A</b>                                                                                                                |  | 17. INFORMANT <b>Anita A. Stoker</b> ADDRESS <b>Same as #13</b>                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypotension due to Pericardial Effusion</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Extensive Anterior Wall Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Insufficiency, ASCVD</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b> |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                      |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                 |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                       |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>                                                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                                                                              |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)                                                               |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                 |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                                                                         |  |
| 22b. SIGNATURE <b>P.V. Karam</b>                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                  |  | DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/> |  | 22c. DATE SIGNED                                                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KANANI</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                  |  | 22e. ADDRESS                                                                                                                                                |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE <b>9/7/82</b>                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>                                                                                                  |  | 23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>MD</b>                                                            |  |
| 24. FUNERAL DIRECTOR NAME <b>Witzke, P.A.</b> ADDRESS <b>1630 Edmondson Ave Catonsville, Md. 21228</b>                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                  |  | 25a. DATE REC'D. BY REGISTRAR <b>SEP 8 1982</b>                                                                                                             |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>                                                                        |  |



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 5 2 2

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                     |                                                       |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                                       |                                                                                                                                                       |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HARVEY E STONER</b>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                     | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 28 82</b> |                                                                                                                                                             | 2b. HOUR<br><b>9:19 PM</b>                                                           |                                                                                                 |                                                                                                                                       |                                                                                                                                                       |  |
| 3. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br><b>WHITE</b>                                                                                                             |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 28 1904</b>                                                                                                      |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b><br>YRS. MONTHS DAYS HOURS MIN.                     |                                                                                                                                       |                                                                                                                                                       |  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                       |                                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.                                  |                                                                                                                                       |                                                                                                                                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES Hosp.</b> |                                                       |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>   |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CLERK</b>                                                                                     |                                                                                                                                                       |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY<br><b>MD BALTO.</b>                                                                                                                                                                                                                                                                                         |  |                                                                                                                                     |                                                       | 13c. CITY OR TOWN<br><b>CATONSVILLE</b>                                                                                                                     |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                                       | 13e. STREET ADDRESS<br><b>215 PRESTON CT.</b>                                                                                                         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                     |                                                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>EFFIE TRADER</b>                                                                                        |                                                                                      |                                                                                                 |                                                                                                                                       |                                                                                                                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.<br><b>215-10-5437</b>                                                                                      |                                                       | 17. INFORMANT<br>ADDRESS<br><b>MARY E. STONER SAME 21228</b>                                                                                                |                                                                                      |                                                                                                 |                                                                                                                                       |                                                                                                                                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br><b>4100</b> IMMEDIATE CAUSE (a) <b>Old + recent myocardial infarct</b><br>DUE TO (b) <b>AS A CONSEQUENCE OF</b><br><b>Hypertensive, atherosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |                                                                                                                                     |                                                       |                                                                                                                                                             |                                                                                      |                                                                                                 | APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH                                                                                          |                                                                                                                                                       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Chronic tuberculosis and pulmonary emphysema</b>                                                                                                                                                                                                                                          |  |                                                                                                                                     |                                                       |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                                       |                                                                                                                                                       |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                    |                                                       |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                   |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)                                                                              |                                                                                      |                                                                                                 |                                                                                                                                       |                                                                                                                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK                                                                                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                              |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                      |                                                                                                 |                                                                                                                                       |                                                                                                                                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-19-1982</b> to <b>9-28-1982</b> , that (I) (we) last saw the deceased alive on <b>before 9-28-1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                          |  |                                                                                                                                     |                                                       |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                                       |                                                                                                                                                       |  |
| 22b. SIGNATURE<br><b>William J. Hicken</b><br><b>Kaushalendra K. Singh</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                     |                                                       | DEGREE<br><b>MD</b>                                                                                                                                         |                                                                                      | 22c. DATE SIGNED<br><b>9/28/82</b>                                                              |                                                                                                                                       | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WILLIAM J. HICKEN</b><br><b>KAUSHALENDRA K. SINGH</b>                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                     |                                                       | 22e. ADDRESS<br><b>St. Agnes Hospital.</b>                                                                                                                  |                                                                                      |                                                                                                 |                                                                                                                                       |                                                                                                                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CEN)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br><b>10-2-82</b>                                                                                                         |                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK CEM</b>                                                                                                |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>                                 |                                                                                                                                       |                                                                                                                                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>HARLEY F. H 6601 FREDERICK AVE</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                     |                                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 4 1982</b>                                                                                                          |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Conner</b>                                            |                                                                                                                                       |                                                                                                                                                       |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



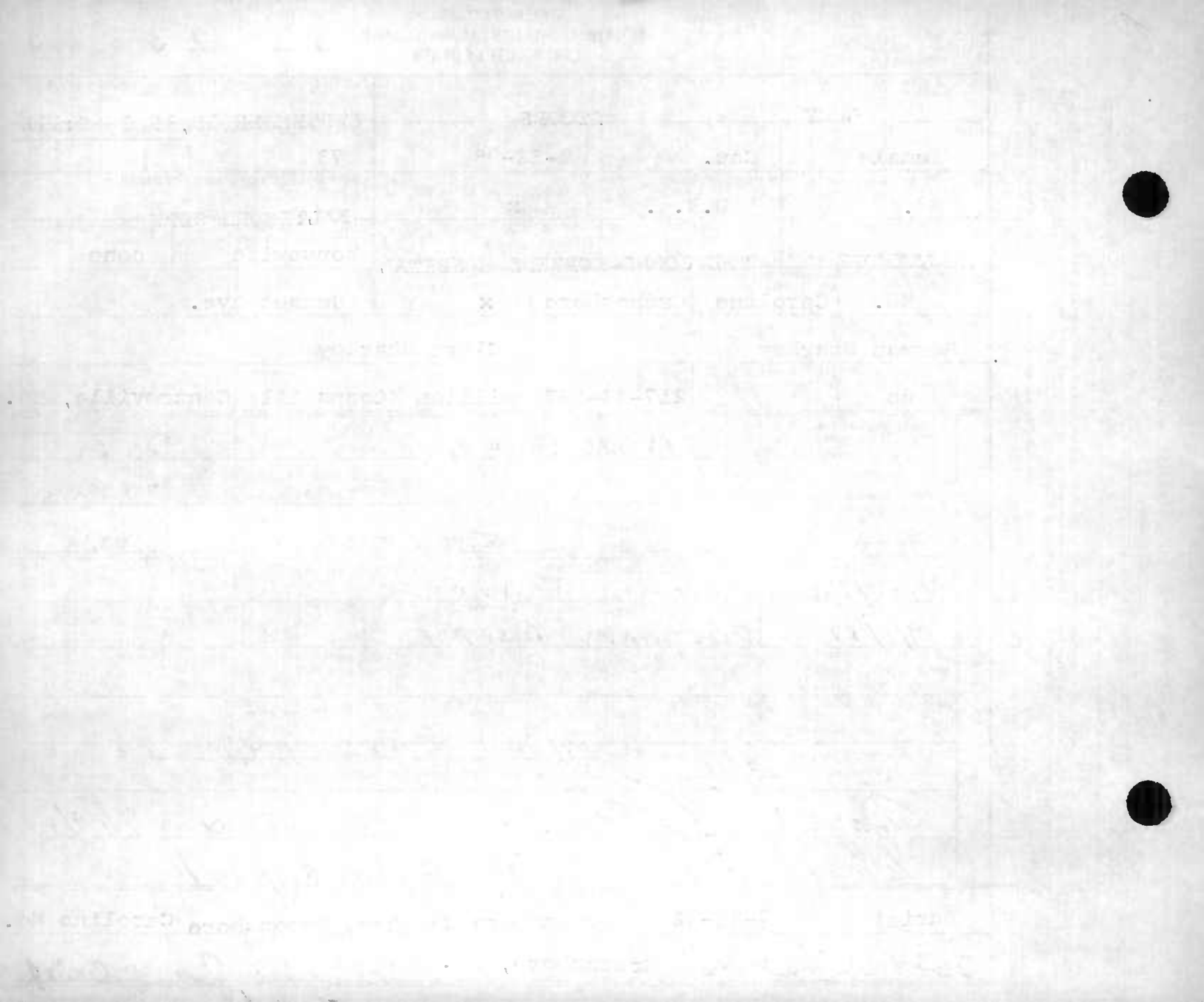
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                         |  |  |                                                                                                                                             |  |                                                                    |                                                                                                                                                             |  |                                                              |                                                                                                                         | 8 2 2 3 5 2 3<br>REG. NO.                                     |                                                               |                                           |                                    |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------|-------------------------------------------|------------------------------------|--|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                       |  |  |                                                                                                                                             |  |                                                                    |                                                                                                                                                             |  |                                                              |                                                                                                                         | 2a. DATE OF DEATH MONTH DAY YEAR                              |                                                               |                                           |                                    |  |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br><b>LUCY STOOPS</b>                                                                                                                                                                                                                                                                                                     |  |  |                                                                                                                                             |  |                                                                    |                                                                                                                                                             |  |                                                              |                                                                                                                         | 2b. HOUR<br><b>9:11 AM</b>                                    |                                                               |                                           |                                    |  |  |
| 3. SEX<br><b>female</b>                                                                                                                                                                                                                                                                                                                                      |  |  | 4. RACE<br><b>Cau.</b>                                                                                                                      |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>9-22-08</b>                  |                                                                                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS<br><b>73</b> |                                                                                                                         |                                                               | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br><b>9-11-82</b> |                                           |                                    |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                      |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                               |  |                                                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                                                       |                                                               |                                                               |                                           |                                    |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |                                                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>housewife</b>                                                                           |  |                                                              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>                                                                        |                                                               |                                                               |                                           |                                    |  |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                     |  |  | 13b. COUNTY<br><b>Caroline</b>                                                                                                              |  |                                                                    | 13c. CITY OR TOWN<br><b>Greensboro</b>                                                                                                                      |  |                                                              | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                                               |                                                               | 13e. STREET ADDRESS<br><b>Sunset Ave.</b> |                                    |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Herman Starkey</b>                                                                                                                                                                                                                                                                                                 |  |  |                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Clara Starkey</b> |                                                                                                                                                             |  |                                                              |                                                                                                                         |                                                               |                                                               |                                           |                                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>                                                                                                                                                                                                                                                   |  |  | 16b. SOCIAL SECURITY NO.<br><b>217-44-1671</b>                                                                                              |  |                                                                    | 17. INFORMANT ADDRESS<br><b>William Stoops 111 Centreville, Md.</b>                                                                                         |  |                                                              |                                                                                                                         |                                                               |                                                               |                                           |                                    |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4149 IMMEDIATE CAUSE (a) CARDIAC Failure</b>                                                                                                                                                                                                   |  |  |                                                                                                                                             |  |                                                                    |                                                                                                                                                             |  |                                                              |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hr.</b> |                                                               |                                           |                                    |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>low Output</b>                                                                                                                                                                                                                                                                                                      |  |  |                                                                                                                                             |  |                                                                    |                                                                                                                                                             |  |                                                              |                                                                                                                         | <b>20 days</b>                                                |                                                               |                                           |                                    |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Coronary artery disease</b>                                                                                                                                                                                                                                                                                         |  |  |                                                                                                                                             |  |                                                                    |                                                                                                                                                             |  |                                                              |                                                                                                                         | <b>Years</b>                                                  |                                                               |                                           |                                    |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Renal/Pulmonary/Hepatic Failure</b>                                                                                                                                                                                |  |  |                                                                                                                                             |  |                                                                    |                                                                                                                                                             |  |                                                              |                                                                                                                         |                                                               |                                                               |                                           |                                    |  |  |
| 19a. DATE OF OPERATION<br><b>9/1/82</b>                                                                                                                                                                                                                                                                                                                      |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CORONARY DISEASE</b>                                                                 |  |                                                                    | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                           |  |                                                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                               |                                                               |                                           |                                    |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                        |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.<br><b>19</b>                                                                              |  |                                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                              |                                                                                                                         |                                                               |                                                               |                                           |                                    |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                       |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                         |  |                                                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                              |                                                                                                                         |                                                               |                                                               |                                           |                                    |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/25</b> 19 <b>82</b> , to <b>9/19</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>9/19</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                                                                                                                                             |  |                                                                    |                                                                                                                                                             |  |                                                              |                                                                                                                         | 22b. SIGNATURE<br><b>Harold Goll</b>                          |                                                               |                                           | 22c. DATE SIGNED<br><b>9/19/82</b> |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Harold Goll</b>                                                                                                                                                                                                                                                                                                  |  |  |                                                                                                                                             |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>                      |                                                                                                                                                             |  |                                                              |                                                                                                                         |                                                               |                                                               |                                           |                                    |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                   |  |  | 23b. DATE<br><b>9-22-82</b>                                                                                                                 |  |                                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greensboro Cemetery</b>                                                                                            |  |                                                              | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Caroline Md.</b>                                                          |                                                               |                                                               |                                           |                                    |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>John E. Boudin</b>                                                                                                                                                                                                                                                                                                           |  |  |                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 22 1982</b>                |                                                                                                                                                             |  |                                                              |                                                                                                                         | 25b. REGISTRAR'S SIGNATURE<br><b>John E. Boudin</b>           |                                                               |                                           |                                    |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 5 2 4

REG. NO.

|                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                 |  | 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Emma Marie Storck                                                                                                                                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9-5-82                                                                                                               |  | 2b. HOUR<br>M                                                                                                              |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br>White                                                                                                                                                                                                                                                                                                                     |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11-8-1897                                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto. City                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                                                                                                                                                                                               |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore, Md.                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN HEALTH FACILITY, GIVE STREET ADDRESS)<br>5917 Leith Walk                                                                                                                                                                                                       |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Home Maker                                                                              |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STREET<br>Md.                                                                                                                                                                                                           |  | 13b. COUNTY<br>Balto. Md.                                                                                                                                                                                                                                                                                                            |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  | 13d. STREET ADDRESS<br>5917 Leith Walk                                                                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Butterhoff                                                                                                                                                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Josephine Giller                                                                                                                                                                                                                                                                    |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES <input type="checkbox"/> OR UNKNOWN)<br>No                                                             |  | 16b. SOCIAL SECURITY NO.<br>215-42-1240                                                                                    |  |
| 17. INFORMANT<br>ADDRESS<br>Claire M. Walter - 5917 Leith Walk                                                                                                                                                                                                                                                               |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>2030 IMMEDIATE CAUSE (a) Multiple Myeloma<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                     |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                                                                                                                                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                               |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.) |  |                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>Charles B. Hutton MD                                                                                                                                                                                                                                                                                       |  | DEGREE                                                                                                                                                                                                                                                                                                                               |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br>9/1/82                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CHARLES B. HUTTON MD                                                                                                                                                                                                                                                                |  | 22e. ADDRESS<br>7600 PSLER DR TOWSON MD                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                       |  | 23b. DATE<br>9-8-82                                                                                                                                                                                                                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer Cem.                                                                                                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.                                                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>John C. Miller Inc-6415 Belair Rd.-21206                                                                                                                                                                                                                                                     |  | ADDRESS                                                                                                                                                                                                                                                                                                                              |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 8 1982                                                                                                                 |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel                                                                               |  |

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Robertson, R.

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Chinese, Walter - 2917 Lake Park

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 5 2 5

REG. NO.

|                                                                   |                                                                                                        |                                                                                                                                                          |                                                                     |                                  |                                   |
|-------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------|-----------------------------------|
| 1. FOR STATE REGISTRAR                                            |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                                     | 2b. HOUR                         |                                   |
| 1. DECEASED NAME (TYPE OR PRINT)                                  |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                                     | 2b. HOUR                         |                                   |
| FIRST MIDDLE LAST                                                 |                                                                                                        | MONTH DAY YEAR                                                                                                                                           |                                                                     | HOURS MIN.                       |                                   |
| STROH PETER J                                                     |                                                                                                        | SEP 14 1982                                                                                                                                              |                                                                     | 1255 PM                          |                                   |
| 3. SEX                                                            | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | IF UNDER 1 YEAR                  |                                   |
| M                                                                 | W                                                                                                      | MONTH DAY YEAR                                                                                                                                           | 38                                                                  | MONTHS DAYS HOURS MIN.           |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                         | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                  |                                   |
| NORTH CAROLINA                                                    | USA                                                                                                    |                                                                                                                                                          | Baltimore City MD.                                                  |                                  |                                   |
| 10. CITY OR TOWN OF DEATH                                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |                                  | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore Hagerstown, MD                                          | UNIV. OF MARYLAND                                                                                      |                                                                                                                                                          | WANG LABS.                                                          |                                  | CUST SVR                          |
| 13a. STATE                                                        | 13b. COUNTY                                                                                            | 13c. CITY OR TOWN                                                                                                                                        | 13d. INSIDE CITY LIMITS?                                            | 13e. STREET ADDRESS              |                                   |
| MD                                                                | Wash.                                                                                                  | Hagerstown                                                                                                                                               | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 1906 ABBEY LANE                  |                                   |
| 14. FATHER'S NAME                                                 |                                                                                                        | 15. MOTHER'S MAIDEN NAME                                                                                                                                 |                                                                     |                                  |                                   |
| FIRST MIDDLE LAST                                                 |                                                                                                        | FIRST MIDDLE LAST                                                                                                                                        |                                                                     |                                  |                                   |
| ALFRED STROH                                                      |                                                                                                        | ERNA MORTENSEN                                                                                                                                           |                                                                     |                                  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) |                                                                                                        | 16b. SOCIAL SECURITY NO.                                                                                                                                 |                                                                     | 17. INFORMANT ADDRESS            |                                   |
| (IF YES, GIVE WAR OR DATES)                                       |                                                                                                        | 113-34-4181                                                                                                                                              |                                                                     | Mrs. Linda Stroh Hagerstown, Md. |                                   |

|                                                                                                                                                                                                                                                                                                                          |                                                                                                                                            |                                                                                |                                                                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                |                                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                   |                                                                     |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                             |                                                                                                                                            |                                                                                |                                                                     |
| IMMEDIATE CAUSE (a) SEPSIS                                                                                                                                                                                                                                                                                               |                                                                                                                                            |                                                                                |                                                                     |
| 2050                                                                                                                                                                                                                                                                                                                     |                                                                                                                                            |                                                                                |                                                                     |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                           |                                                                                                                                            |                                                                                |                                                                     |
| (b) ACUTE MYELOGENOUS LEUKEMIA                                                                                                                                                                                                                                                                                           |                                                                                                                                            |                                                                                |                                                                     |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                           |                                                                                                                                            |                                                                                |                                                                     |
| (c)                                                                                                                                                                                                                                                                                                                      |                                                                                                                                            |                                                                                |                                                                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                      |                                                                                                                                            |                                                                                |                                                                     |
| NONE                                                                                                                                                                                                                                                                                                                     |                                                                                                                                            |                                                                                |                                                                     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                           | 20a. AUTOPSY?                                                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |
| NONE                                                                                                                                                                                                                                                                                                                     |                                                                                                                                            | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                       | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                     |
|                                                                                                                                                                                                                                                                                                                          | P.M. 19                                                                                                                                    |                                                                                |                                                                     |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                                                                     |
|                                                                                                                                                                                                                                                                                                                          |                                                                                                                                            |                                                                                |                                                                     |
| 22a. I certify that (I) (this hospital) attended the deceased from 20 August 1982, to 14 Sept. 1982, that (I) (we) lost saw the deceased alive on 14 Sept 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                                                            |                                                                                |                                                                     |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                           | DEGREE                                                                                                                                     | 22c. DATE SIGNED                                                               |                                                                     |
| T B Kentro MD                                                                                                                                                                                                                                                                                                            | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 9/14/82                                                                        |                                                                     |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                    | 22e. ADDRESS                                                                                                                               |                                                                                |                                                                     |
| T B KENTRO                                                                                                                                                                                                                                                                                                               | C/O UMCL; 22 S. GREENE ST Baltimore                                                                                                        |                                                                                |                                                                     |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                | 23b. DATE                                                                                                                                  | 23c. NAME OF CEMETERY OR CREMATORY                                             | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |
| Cremation                                                                                                                                                                                                                                                                                                                | 9/16/82                                                                                                                                    | Westview Memorial                                                              | Catonsville Maryland                                                |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                |                                                                                                                                            | 25a. DATE REC'D. BY REGISTRAR                                                  |                                                                     |
| Ambrose Funeral Home, Inc. 1328 Sulphur Spring                                                                                                                                                                                                                                                                           |                                                                                                                                            | SEP 16 1982                                                                    |                                                                     |
| ADDRESS                                                                                                                                                                                                                                                                                                                  |                                                                                                                                            | 25b. REGISTRAR'S SIGNATURE                                                     |                                                                     |
|                                                                                                                                                                                                                                                                                                                          |                                                                                                                                            | John J. [Signature]                                                            |                                                                     |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 5 2 6

REG. NO.

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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <u>HOMER</u> MIDDLE <u>G</u> LAST <u>SUDOR</u><br><u>Homer G Sudor</u>                                                                                                                                                                                                                                                    |                                                                                                                                          | 2a. DATE OF DEATH<br>MONTH <u>9</u> DAY <u>7</u> YEAR <u>82</u><br>2b. HOUR<br><u>3:30 PM</u>                                                               |                                                                                                                                                  |
| 3. SEX<br><u>male</u>                                                                                                                                                                                                                                                                                                                                                  | 4. RACE<br><u>white</u><br><u>caucasian</u>                                                                                              | 5. DATE OF BIRTH<br>MONTH <u>3</u> DAY <u>19</u> YEAR <u>22</u>                                                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>60</u> YRS.<br>IF UNDER 1 YEAR: MONTHS <u></u> DAYS <u></u><br>IF UNDER 24 HRS: HOURS <u></u> MIN. <u></u> |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Pennsylvania</u>                                                                                                                                                                                                                                                                                                        | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                                                                               | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City</u> MD.                                                                                |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore Md</u>                                                                                                                                                                                                                                                                                                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>South Baltimore Genl</u> | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Supervisor</u>                                                                       | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Beth Steel Key</u>                                                                                       |
| 13a. STATE<br><u>Md</u>                                                                                                                                                                                                                                                                                                                                                | 13b. COUNTY<br><u>XXXXXX</u>                                                                                                             | 13c. CITY OR TOWN<br><u>Baltimore</u>                                                                                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                  |
| 14. FATHER'S NAME<br>FIRST <u>Homer</u> MIDDLE <u>G</u> LAST <u>Sudor</u>                                                                                                                                                                                                                                                                                              | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>Edith</u> MIDDLE <u>Venhuis</u> LAST <u></u>                                                        | 13e. STREET ADDRESS<br><u>3814 headen hall sta</u><br><u>Highway 95</u>                                                                                     |                                                                                                                                                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>Yes</u>                                                                                                                                                                                                                                                                                     | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><u>1943-46</u>                                                                | 17. INFORMANT<br><u>Bessie Sudor</u>                                                                                                                        | ADDRESS<br><u>Baltimore, Md. 21225</u><br><u>3814 headen hall</u>                                                                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><u>4100</u><br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u></u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>5 days</u>                   |                                                                                                                                          |                                                                                                                                                             |                                                                                                                                                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Cerebral Anoxia</u>                                                                                                                                                                                                          |                                                                                                                                          |                                                                                                                                                             |                                                                                                                                                  |
| 19a. DATE OF OPERATION<br><u>19</u>                                                                                                                                                                                                                                                                                                                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u></u>                                                                              | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u></u> P.M. <u>19</u>                                                                | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |                                                                                                                                                  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><u></u>                                                        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><u></u>                                                                                                |                                                                                                                                                  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 2</u> , 19 <u>82</u> to <u>Sept 9</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>Sept 9</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                                                          |                                                                                                                                                             |                                                                                                                                                  |
| 22b. SIGNATURE<br><u>H.G. Hebard</u>                                                                                                                                                                                                                                                                                                                                   | DEGREE<br><u></u>                                                                                                                        | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  | 22c. DATE SIGNED<br><u>Sept 9, 1982</u>                                                                                                          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>H.G. Hebard</u>                                                                                                                                                                                                                                                                                                            | 22e. ADDRESS<br><u>South Baltimore General Hospital</u>                                                                                  |                                                                                                                                                             |                                                                                                                                                  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>burial</u>                                                                                                                                                                                                                                                                                                             | 23b. DATE<br><u>9/10/82</u>                                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Glen Haven Cemetery</u>                                                                                            | 23d. LOCATION<br>CITY OR TOWN <u>Glen Burnie</u> COUNTY <u>A.A.</u> STATE <u>Md.</u>                                                             |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Gonce F.H., P.A.</u>                                                                                                                                                                                                                                                                                                                |                                                                                                                                          | 25a. DATE REC'D. BY REGISTRAR<br><u>SEP 10 1982</u>                                                                                                         |                                                                                                                                                  |
| ADDRESS<br><u>4001 Ritchie Hwy</u>                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                          | REGISTRAR'S SIGNATURE<br><u>J. J. Conner</u>                                                                                                                |                                                                                                                                                  |

Administrative

Final - WAVE for given construction under A.A. 101

June 1, 1961, P.M. 10:00 AM. WAVE 10:00 AM. 10:00 AM.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

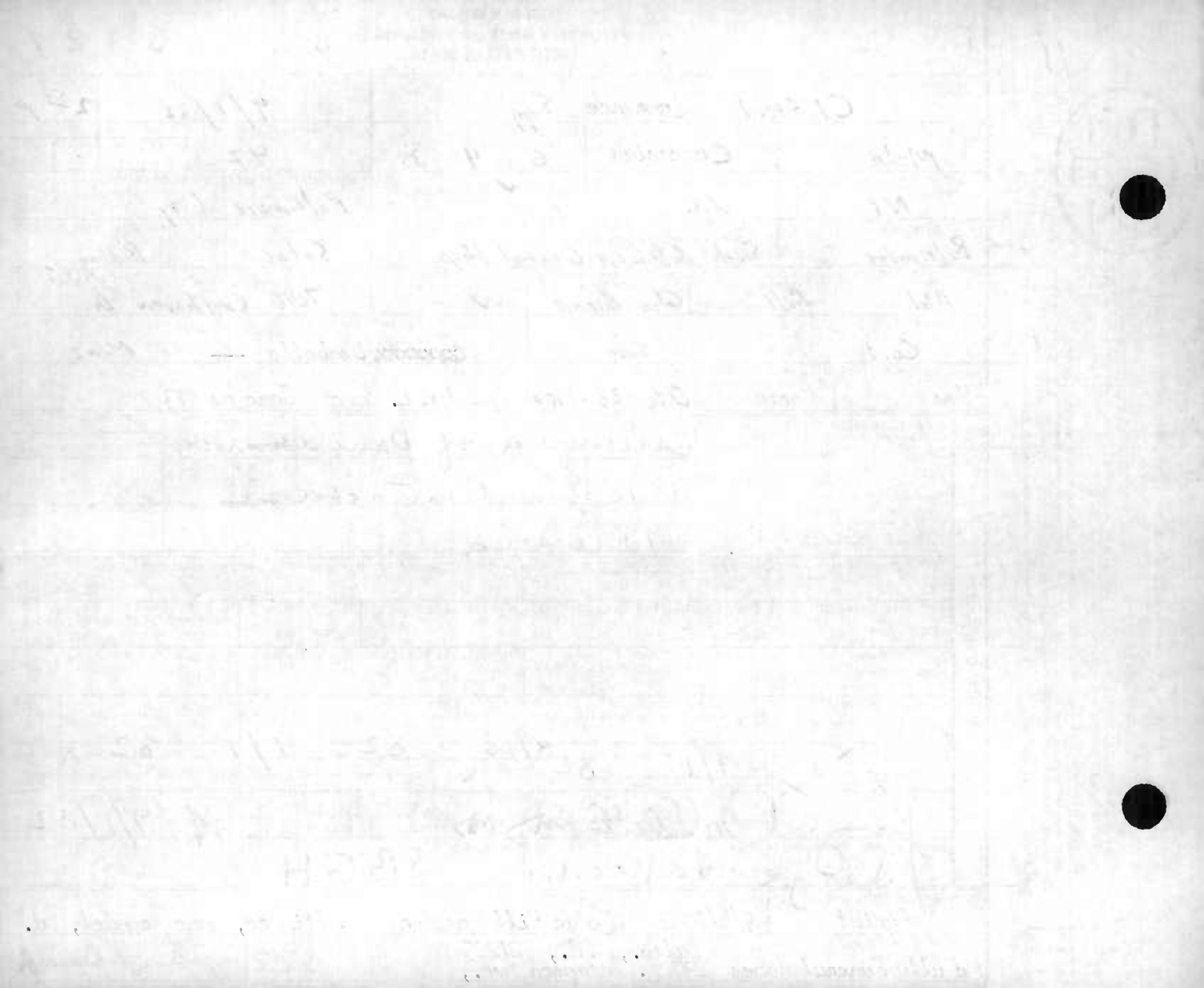
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                         |  |                                  |  |                                              |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|----------------------------------|--|----------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 8 2 2 3 5 2 7                                                                                          |  | REG. NO.                                                                                                                                                 |  |                                                                                                                         |  |                                  |  |                                              |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                             |  | FIRST                                                                                                  |  | MIDDLE                                                                                                                                                   |  | LAST                                                                                                                    |  | 2a. DATE OF DEATH MONTH DAY YEAR |  | 2b. HOUR                                     |  |
| C. I. Ford                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | Lawrence                                                                                               |  | Sugg                                                                                                                                                     |  |                                                                                                                         |  | 9/1/82                           |  | 2:50 PM                                      |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                         |  | IF UNDER 1 YEAR MONTHS DAYS      |  | IF UNDER 24 HRS HOURS MIN                    |  |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | Caucasian                                                                                              |  | 6 4 35                                                                                                                                                   |  | 47 YRS                                                                                                                  |  |                                  |  |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                    |  |                                  |  |                                              |  |
| NY                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | U.S.                                                                                                   |  |                                                                                                                                                          |  | Baltimore City                                                                                                          |  |                                  |  | MD                                           |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |  |                                  |  |                                              |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | South Baltimore General Hosp                                                                           |  | Sales                                                                                                                                                    |  | Baking                                                                                                                  |  |                                  |  | 21067                                        |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                 |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS              |  |                                              |  |
| Md                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | Baltimore                                                                                              |  | Glen Burnie                                                                                                                                              |  |                                                                                                                         |  | 7010 Cresthaven Dr.              |  |                                              |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                             |  |                                                                                                                                                          |  |                                                                                                                         |  |                                  |  |                                              |  |
| Carl                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | Sugg                                                                                                   |  | Charlotte Isabelle                                                                                                                                       |  | Munz                                                                                                                    |  |                                  |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.                                                                               |  | 17. INFORMANT ADDRESS                                                                                                                                    |  |                                                                                                                         |  |                                  |  |                                              |  |
| Yes                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | Korea                                                                                                  |  | 090-26-1907                                                                                                                                              |  | Carolyn L. Sugg                                                                                                         |  | Same as #13                      |  |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>1579 IMMEDIATE CAUSE (a) Carcinoma of Pancreas with<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Widespread metastasis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Leukemia                                                                                                                                                            |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                         |  |                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                          |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                         |  |                                  |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                  |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                           |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                                                                         |  |                                  |  |                                              |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                         |  |                                  |  |                                              |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/1/82, 19 82, to 9/1/82, 19 82, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 9/1/82, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                         |  |                                  |  |                                              |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                               |  | DEGREE                                                                                                 |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED                                                                                                        |  |                                  |  |                                              |  |
| George Vallecillo                                                                                                                                                                                                                                                                                                                                                                                                                            |  | MD                                                                                                     |  | SBGH                                                                                                                                                     |  | 9/1/82                                                                                                                  |  |                                  |  |                                              |  |
| 23a. BURIAL CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                                                 |  |                                  |  |                                              |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 9/4/1982                                                                                               |  | Cedar Hill Cemetery                                                                                                                                      |  | Baltimore, Anne Arundel, Md.                                                                                            |  |                                  |  |                                              |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 24b. ADDRESS                                                                                           |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |  | 25b. REGISTRAR'S SIGNATURE                                                                                              |  |                                  |  |                                              |  |
| McCully Funeral Homes                                                                                                                                                                                                                                                                                                                                                                                                                        |  | Baltimore, Md., 21225                                                                                  |  | SEP 3 1982                                                                                                                                               |  | John J. Connel                                                                                                          |  |                                  |  |                                              |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. There please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                     |  |                                                                                                     |                   |                                                                                                                                                           |      |                                                                                                                                                |  |                            |  | 8 2 2 3 5 2 8                                                  |  |          |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|-------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|------|------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------|--|----------------------------------------------------------------|--|----------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                   |  |                                                                                                     | REG. NO.          |                                                                                                                                                           |      |                                                                                                                                                |  |                            |  |                                                                |  |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                      |  |                                                                                                     | 2a. DATE OF DEATH |                                                                                                                                                           |      | MONTH                                                                                                                                          |  | DAY                        |  | YEAR                                                           |  | 2b. HOUR |  |
| KATHRYN BECKER SUMMERS                                                                                                                                                                                                                                                                                                                   |  |                                                                                                     | SEPTEMBER 19, 82  |                                                                                                                                                           | 4 AM |                                                                                                                                                |  |                            |  |                                                                |  |          |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE                                                                                             |                   | 5. DATE OF BIRTH                                                                                                                                          |      | 6. AGE - (IN YEARS LAST BIRTHDAY)                                                                                                              |  | 7. IF UNDER 1 YEAR         |  | 8. IF UNDER 24 HRS                                             |  |          |  |
| FEMALE                                                                                                                                                                                                                                                                                                                                   |  | WHITE                                                                                               |                   | AUGUST 7, 1896                                                                                                                                            |      | 86 YRS                                                                                                                                         |  | MONTHS                     |  | DAYS                                                           |  | HOURS    |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                 |  | 10. CITIZEN OF WHAT COUNTRY?                                                                        |                   | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 12. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                          |  |                            |  |                                                                |  |          |  |
| BALTIMORE, MD.                                                                                                                                                                                                                                                                                                                           |  | USA                                                                                                 |                   |                                                                                                                                                           |      | BALTIMORE CITY                                                                                                                                 |  |                            |  |                                                                |  | MD.      |  |
| 13. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                |  | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                   | 15. USUAL OCCUPATION (TYPE OF WORK OR MODEL OF WORKING LIFE)                                                                                              |      | 16. KIND OF BUSINESS OR INDUSTRY                                                                                                               |  |                            |  |                                                                |  |          |  |
| BALTIMORE                                                                                                                                                                                                                                                                                                                                |  | LONG GREEN NURSING HOME                                                                             |                   | HOMEMAKER                                                                                                                                                 |      |                                                                                                                                                |  |                            |  |                                                                |  |          |  |
| 17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                              |  | 18. STATE                                                                                           |                   | 19. COUNTY                                                                                                                                                |      | 20. CITY OR TOWN                                                                                                                               |  | 21. INSIDE CITY LIMITS?    |  | 22. STREET ADDRESS                                             |  |          |  |
| MD.                                                                                                                                                                                                                                                                                                                                      |  | BALTIMORE                                                                                           |                   | TOWSON                                                                                                                                                    |      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                            |  | 7315 YORKTOWNE DR. 21204   |  |                                                                |  |          |  |
| 23. FATHER'S NAME (FIRST MIDDLE LAST)                                                                                                                                                                                                                                                                                                    |  | 24. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)                                                        |                   | 25. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                                                              |      | 26. SOCIAL SECURITY NO.                                                                                                                        |  | 27. INFORMANT              |  | 28. ADDRESS                                                    |  |          |  |
| CHARLES BECKER                                                                                                                                                                                                                                                                                                                           |  | LENA QUENTEL                                                                                        |                   | NO                                                                                                                                                        |      | 219-28-7729                                                                                                                                    |  | ROBERT W. SUMMERS          |  | 7315 YORKTOWNE DR 21204                                        |  |          |  |
| 29. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>4360 IMMEDIATE CAUSE (a) Cerebral Vascular accident<br>(b) Cerebral arteriosclerosis<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, last |  |                                                                                                     |                   |                                                                                                                                                           |      |                                                                                                                                                |  |                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 wks<br>1 wks |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                      |  |                                                                                                     |                   |                                                                                                                                                           |      |                                                                                                                                                |  |                            |  |                                                                |  |          |  |
| 30. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                    |  | 31. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                     |                   | 32. AUTOPSY?                                                                                                                                              |      | 33. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                                                                                  |  |                            |  |                                                                |  |          |  |
| YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                 |  |                                                                                                     |                   | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                  |      | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                       |  |                            |  |                                                                |  |          |  |
| 34. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                        |  | 35. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                           |                   | 36. HOW INJURY OCCURRED (ENTER NATURE OF INJURY EXTENT, IN PART 1 OR PART 2)                                                                              |      |                                                                                                                                                |  |                            |  |                                                                |  |          |  |
| 37. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>                                                                                                                                                                               |  | 38. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM, ETC.)                                   |                   | 39. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                          |      |                                                                                                                                                |  |                            |  |                                                                |  |          |  |
| 40. I certify that (I) (this hospital) attended the deceased from<br>saw the deceased alive on 9/14/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If the deceased did not view the body after death, so state.)                                                               |  | 41. SIGNATURE<br>NORMAN R. FREEMAN                                                                  |                   | 42. DEGREE<br>M.D.                                                                                                                                        |      | 43. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 44. DATE SIGNED<br>9/20/82 |  |                                                                |  |          |  |
| 45. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                     |  | 46. ADDRESS                                                                                         |                   | 47. NAME OF CEMETERY OR CREMATORY                                                                                                                         |      | 48. LOCATION<br>CITY OR TOWN COUNTY STATE                                                                                                      |  |                            |  |                                                                |  |          |  |
| BURL                                                                                                                                                                                                                                                                                                                                     |  | SEPT. 22, 1982                                                                                      |                   | LOUDON PARK CEM.                                                                                                                                          |      | BALTIMORE                                                                                                                                      |  |                            |  |                                                                |  | MD.      |  |
| 49. FUNERAL DIRECTOR<br>NAME ADDRESS                                                                                                                                                                                                                                                                                                     |  | 50. DATE REC'D BY REGISTRAR                                                                         |                   | 51. REGISTRAR'S SIGNATURE                                                                                                                                 |      |                                                                                                                                                |  |                            |  |                                                                |  |          |  |
| MITCHELL-WIEDEFELD HOME 6500 YORK RD. 21212                                                                                                                                                                                                                                                                                              |  | SEP 27 1982                                                                                         |                   | John J. Carver                                                                                                                                            |      |                                                                                                                                                |  |                            |  |                                                                |  |          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                        |  | 8 2 2 3 5 2 9<br>REG. NO.                                                                                                                                   |  |                                                                                                     |  |                                                                                                                               |  |
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| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GEORGE EDWIN SURESCH</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                        |  | 2a. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>21</b> YEAR <b>82</b>                                                                                            |  |                                                                                                     |  | 2b. HOUR<br><b>1:45</b> A.M.                                                                                                  |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br><b>White</b>                                                                                                                |  | 5. DATE OF BIRTH<br>MONTH <b>Oct</b> DAY <b>26</b> YEAR <b>1904</b>                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                                                   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                                                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                          |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.                                        |  |                                                                                                                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Sup't Contractor</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                             |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                        |  | 13b. COUNTY<br><b>Howard</b>                                                                                                                                |  | 13c. CITY OR TOWN<br><b>Ellicott City</b>                                                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                          |  |
| 14. FATHER'S NAME<br>FIRST <b>late Conrad Suresch</b> MIDDLE <b></b> LAST <b></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>late Katherine Schmidt</b> MIDDLE <b></b> LAST <b></b>                                                                 |  |                                                                                                     |  |                                                                                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO.<br><b>213 10 9436</b>                                                                                         |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs Mabel Suresch 8672 Old Fred'k RD 21043</b>                                                                               |  |                                                                                                     |  |                                                                                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Metastatic Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Squamous cell carcinoma of right lung.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                     |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Chronic obstructive Pulmonary disease</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                     |  |                                                                                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                           |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                     |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                     |  |                                                                                                                               |  |
| 22a. I certify that (this hospital) attended the deceased from <b>8/30/1982</b> to <b>9/21/1982</b> , that (we) lost saw the deceased alive on <b>9/20/1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz) |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                     |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><b>B.K. SINHA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | DEGREE                                                                                                                                 |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |                                                                                                     |  | 22c. DATE SIGNED<br><b>9/21/82</b>                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B.K. SINHA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 22e. ADDRESS<br><b>ST. AGNES HOSPITAL<br/>BALTIMORE, MD.</b>                                                                           |  |                                                                                                                                                             |  |                                                                                                     |  |                                                                                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br><b>Sept 24 '82</b>                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>                                                                                                    |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE <b></b>                 |  |                                                                                                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Harry H Witzke</b> ADDRESS <b>4112 Columbia Ellicott City</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 23 1982</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                                 |  |                                                                                                                               |  |

Oct 25, 1904

Miss

Miss

Bellevue

U.S.A.

Bellevue

Bellevue Hospital

Bellevue

Bellevue Hospital

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Bellevue Hospital

Bellevue Hospital

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

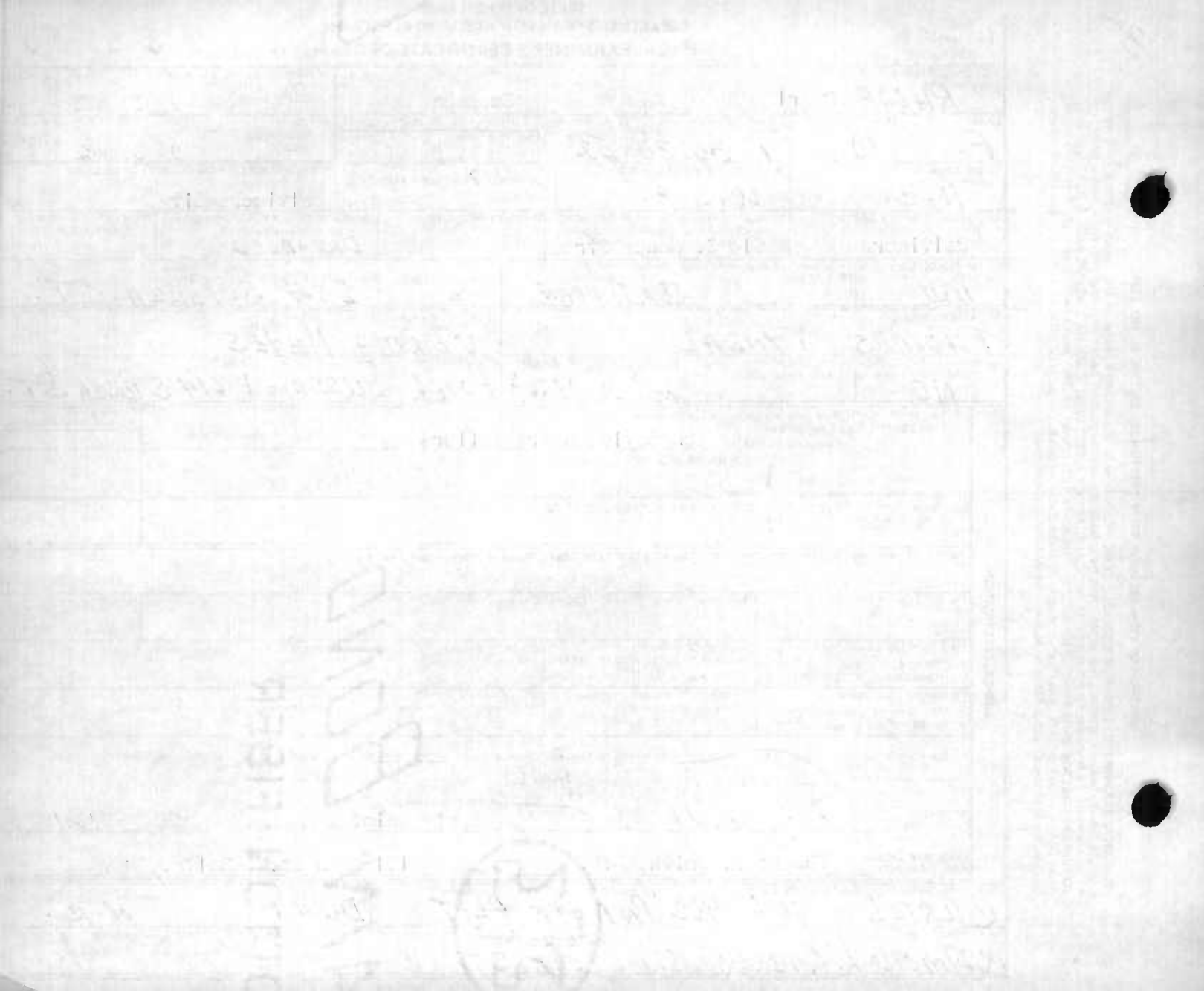
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20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 2 3 5 3 0

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                   |               |                                                                                                                                   |                              |                                                                                                                                                             |                                               |                                                                           |  |                                                                                     |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------------------------------------------------------------------------------------|------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|---------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>RHODA Pearl                                                                                                                                                                                                                                                                                                                                                                                                |               |                                                                                                                                   |                              | 2a. DATE KNOWN OF DEATH<br>9 30 1982                                                                                                                        |                                               |                                                                           |  | 2b. HOUR<br>M                                                                       |  |
| 3. SEX<br>F.                                                                                                                                                                                                                                                                                                                                                                                                                                      | 4. RACE<br>W. | 5. DATE OF BIRTH<br>1 30 30                                                                                                       | 6. AGE (IN YEARS)<br>52 YRS. | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                                                                                                 | 8. IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN. | 2c. DATE PRONOUNCED DEAD<br>9 30 1982                                     |  | 2d. HOUR<br>8:40 M                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.                                                                                                                                                                                                                                                                                                                                                                                                 |               | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                            |                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.               |  |                                                                                     |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                            |               | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>614 S. Ponca Street |                              |                                                                                                                                                             |                                               | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>DISABLED |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                   |  |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                  |               | 13b. COUNTY<br>BALTIMORE                                                                                                          |                              | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |                                               | 13e. STREET ADDRESS<br>614 S. PONCA ST.                                   |  |                                                                                     |  |
| 14. FATHER'S NAME<br>THOMAS TYNDALL                                                                                                                                                                                                                                                                                                                                                                                                               |               |                                                                                                                                   |                              | 15. MOTHER'S MAIDEN NAME<br>VELMA HAYES                                                                                                                     |                                               |                                                                           |  |                                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                                       |               | 16b. SOCIAL SECURITY NO.<br>245 36 7826A                                                                                          |                              | 17. INFORMANT ADDRESS<br>PAUL SUSSMAN 614 S. PONCA ST.                                                                                                      |                                               |                                                                           |  |                                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Congestive heart failure<br>4280<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |               |                                                                                                                                   |                              |                                                                                                                                                             |                                               |                                                                           |  |                                                                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                               |               |                                                                                                                                   |                              |                                                                                                                                                             |                                               |                                                                           |  |                                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                            |               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                 |                              |                                                                                                                                                             |                                               |                                                                           |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                               |               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                        |                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |                                               |                                                                           |  |                                                                                     |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                   |               | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                       |                              | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                               |                                                                           |  |                                                                                     |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .   |               |                                                                                                                                   |                              |                                                                                                                                                             |                                               |                                                                           |  |                                                                                     |  |
| ACTUAL SIGNATURE<br>Thomas D. Smith                                                                                                                                                                                                                                                                                                                                                                                                               |               | TITLE (SPECIFY)<br>M.D. Deputy Chief                                                                                              |                              |                                                                                                                                                             |                                               | DATE SIGNED<br>9/30/82                                                    |  |                                                                                     |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Thomas D. Smith, M.D.                                                                                                                                                                                                                                                                                                                                                                                          |               | ADDRESS<br>111 Penn St. Balto., Md.                                                                                               |                              |                                                                                                                                                             |                                               |                                                                           |  |                                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                         |               | 23b. DATE<br>10 6 1982                                                                                                            |                              | 23c. NAME OF CEMETERY OR CREMATORY<br>PRIVATE PLOT                                                                                                          |                                               | 23d. LOCATION<br>DUNN COUNTY N.C.                                         |  |                                                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>RAYMOND L. KACZOROWSKI                                                                                                                                                                                                                                                                                                                                                                                            |               | ADDRESS<br>2525 FLEET ST.                                                                                                         |                              | 25a. DATE REC'D BY REGISTRAR<br>OCT 13 1982                                                                                                                 |                                               | 25b. REGISTRAR'S SIGNATURE<br>John J. Gmeh                                |  |                                                                                     |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 5 3 1

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                           |                                                                                                                                                             |                                                                  |                                                                                                                                                 |                                                                     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                        |                                                                                                           | 2a. DATE OF DEATH                                                                                                                                           |                                                                  | 2b. HOUR                                                                                                                                        |                                                                     |
| 1 DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                  |                                                                                                           | MONTH DAY YEAR                                                                                                                                              |                                                                  | MONTHS DAYS HOURS MIN.                                                                                                                          |                                                                     |
| JOYCE RAY SWAYNE                                                                                                                                                                                                                                                                                                                                                    |                                                                                                           | SEPTEMBER 14, 1982                                                                                                                                          |                                                                  | 1:45am                                                                                                                                          |                                                                     |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                              | 4. RACE                                                                                                   | 5. DATE OF BIRTH                                                                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)                                  | IF UNDER 1 YEAR IF UNDER 24 HRS                                                                                                                 |                                                                     |
| FEMALE                                                                                                                                                                                                                                                                                                                                                              | NEGRO                                                                                                     | MONTH DAY YEAR<br>JULY 26 1929                                                                                                                              | 53 YRS                                                           | MONTHS DAYS HOURS MIN.                                                                                                                          |                                                                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                           | 7b. CITIZEN OF WHAT COUNTRY?                                                                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |                                                                                                                                                 |                                                                     |
| WEST VIRGINIA                                                                                                                                                                                                                                                                                                                                                       | U.S.A.                                                                                                    |                                                                                                                                                             | BALTIMORE CITY MD.                                               |                                                                                                                                                 |                                                                     |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                           | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                   |
| BALTIMORE                                                                                                                                                                                                                                                                                                                                                           | THE JOHNS HOPKINS HOSPITAL                                                                                |                                                                                                                                                             | SCHOOL TEACHER                                                   |                                                                                                                                                 | DEPT OF EDU                                                         |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                          |                                                                                                           | 13b. CITY OR TOWN                                                                                                                                           | 13c. STREET ADDRESS                                              |                                                                                                                                                 | 13d. INSIDE CITY LIMITS?                                            |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           | BALTIMORE                                                                                                                                                   | 21207                                                            |                                                                                                                                                 | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                   |                                                                                                           | 15. MOTHER'S MAIDEN NAME                                                                                                                                    |                                                                  | ADDRESS                                                                                                                                         |                                                                     |
| FIRST MIDDLE LAST<br>GEORGE THOMAS RAY                                                                                                                                                                                                                                                                                                                              |                                                                                                           | FIRST MIDDLE LAST<br>ROSABELLE OWEN                                                                                                                         |                                                                  | 21207                                                                                                                                           |                                                                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                |                                                                                                           | 16b. SOCIAL SECURITY NO.                                                                                                                                    |                                                                  | 17. INFORMANT                                                                                                                                   |                                                                     |
| NO                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                           | 232-46-0988                                                                                                                                                 |                                                                  | OPHIA L. SWAYNE/3670 FOREST GARDEN AV                                                                                                           |                                                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic Breast Carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pleural Effusion, Multiple Bone Lesions, hypercalcemia</u>                       |                                                                                                           |                                                                                                                                                             |                                                                  |                                                                                                                                                 | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                 |                                                                                                           |                                                                                                                                                             |                                                                  |                                                                                                                                                 |                                                                     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                              |                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                  | 20a. AUTOPSY?                                                                                                                                   |                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                           |                                                                                                                                                             |                                                                  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                             |                                                                     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                             |                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                  |                                                                     |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                        |                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                               |                                                                     |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/26/82</u> 19 <u>82</u> to <u>9/14/82</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>9/14/82</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                           | 22b. SIGNATURE<br><u>Ana N Sawer</u>                                                                                                                        |                                                                  | 22c. DATE SIGNED<br><u>9/14/82</u>                                                                                                              |                                                                     |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>AMAR N SARWAL</u>                                                                                                                                                                                                                                                                                                       |                                                                                                           | 22e. ADDRESS<br><u>Dept of Onc John Hopkins Baltimore.</u>                                                                                                  |                                                                  | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                     |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                        |                                                                                                           | 23b. DATE                                                                                                                                                   |                                                                  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                              |                                                                     |
| burial                                                                                                                                                                                                                                                                                                                                                              |                                                                                                           | 09/18/82                                                                                                                                                    |                                                                  | WOODLAWN CEMETERY                                                                                                                               |                                                                     |
| 24. FUNERAL DIRECTOR<br><u>MARSHALL W JONES, JR/4101</u>                                                                                                                                                                                                                                                                                                            |                                                                                                           | 24b. ADDRESS<br><u>EDMONDSON AVE</u>                                                                                                                        |                                                                  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                   |                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                           |                                                                                                                                                             |                                                                  | SEP 16 1982                                                                                                                                     |                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                           |                                                                                                                                                             |                                                                  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Conner</u>                                                                                             |                                                                     |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                    |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                               |                                                                                       |                                                                         |                                                                                                                            |                                                                                                 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                               |                                                                                       |                                                                         |                                                                                                                            |                                                                                                 |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Raymond Sweglar</b>                                                                                                                                                                                                                                                                                      |  |                                                                                                                                             |                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept. 10, 1982</b>  |                                                                                       | 2b. HOUR<br><b>10<sup>30</sup> AM</b>                                   |                                                                                                                            |                                                                                                 |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br><b>White</b>                                                                                                                     |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 12, 1903</b>                                                                                                   |                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS                                      |                                                                         | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                         |                                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                               |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                     |                                                                         |                                                                                                                            |                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |                                                                        |                                                                                                                                                             |                                                               | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supervisor</b> |                                                                         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Western Electric</b>                                                               |                                                                                                 |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                           |  |                                                                                                                                             |                                                                        |                                                                                                                                                             | 13b. COUNTY                                                   |                                                                                       | 13c. CITY OR TOWN<br><b>Baltimore</b>                                   |                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Eugene Sweglar</b>                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                             |                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mabel</b> |                                                                                       |                                                                         |                                                                                                                            |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                           |  |                                                                                                                                             |                                                                        |                                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br><b>215-10-4225</b>                |                                                                                       | 17. INFORMANT<br>ADDRESS<br><b>Madeline Sweglar 3015 Echodale Ave.</b>  |                                                                                                                            |                                                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4100 Acute coronary occlusion</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary insufficiency</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>2 weeks</b>                                                                     |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                               |                                                                                       |                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |                                                                                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                    |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                               |                                                                                       |                                                                         |                                                                                                                            |                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                                                         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                |  |                                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)        |                                                                         |                                                                                                                            |                                                                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                          |  |                                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |                                                                         |                                                                                                                            |                                                                                                 |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>Jul 21</b> , 19 <b>69</b> , to <b>Sept 10</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>Sept 10</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                               |                                                                                       |                                                                         |                                                                                                                            |                                                                                                 |  |
| 22b. SIGNATURE<br><b>R. Donald J. Jandorff M.D.</b> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                                                                                                                                                                |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                               | 22c. DATE SIGNED<br><b>9-10-82</b>                                                    |                                                                         |                                                                                                                            |                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Donald B. Jandorff</b>                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                               | 22e. ADDRESS<br><b>7403 Harford Road Baltimore, Maryland</b>                          |                                                                         |                                                                                                                            |                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                             | 23b. DATE<br><b>Sept. 13, 1982</b>                                     |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>         |                                                                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |                                                                                                                            |                                                                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                               | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 14 1982</b>                                   |                                                                         | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Gansler</b>                                                                       |                                                                                                 |  |

1991, 51, 1991

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 showing any injury, or other traumatic event, the medical examiner must be notified immediately.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                          |  | REG. NO. 8 2 2 3 5 3 3                                                                                                                               |  |                                                                                |                                                                                 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                          |  |                                                                                                                                                      |  |                                                                                |                                                                                 |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Josephine Gregorek Szwabowski                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                          |  | 2a. DATE OF DEATH<br>9/10/82                                                                                                                         |  | 2b. HOUR<br>2:30AM                                                             |                                                                                 |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br>Cauc.                                                                                                                         |  | 5. DATE OF BIRTH<br>3/10/02                                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80                                          |                                                                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Poland                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                      |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |                                                                                 |
| 10. CITY OR TOWN OF DEATH<br>Balto.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>401 Southway, Balto. Md. 21218 |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-                                         |                                                                                 |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                          |  | 13b. COUNTY<br>-                                                                                                                                     |  | 13c. CITY OR TOWN<br>Balto.                                                    |                                                                                 |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)<br>Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)<br>Unknown                                                                                              |  |                                                                                |                                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.<br>215-58-4461                                                                                                              |  | 17. INFORMANT ADDRESS<br>Jane Kihn, 401 Southway, 21218                        |                                                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest -</u><br>4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>CVA (stroke)</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>CVA (stroke)</u> |  |                                                                                                                                          |  |                                                                                                                                                      |  |                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>few min</u><br><u>10 min</u> |
| 19a. DATE OF OPERATION<br><u>7/10/82</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>CVA (stroke)</u>                                                                              |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |                                                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                                                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE, FARM, ETC.)                                                                                  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/2</u> 19 <u>1978</u> , to <u>9/10</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>9/10</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                    |  |                                                                                                                                          |  |                                                                                                                                                      |  |                                                                                |                                                                                 |
| 22b. SIGNATURE<br><u>Miriam Feldman MD</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                          |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED                                                               |                                                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Feldman                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                          |  | 22e. ADDRESS<br>6610 Cross Country Blvd., Balto., Md.                                                                                                |  |                                                                                |                                                                                 |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE<br>9/14/82                                                                                                                     |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Rosary                                                                                                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md.                      |                                                                                 |
| 24. FUNERAL DIRECTOR<br>Schimunek Funeral Home, Inc.<br>3331 Brehms Lane, Balto., Md. 21213                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                          |  | 25. DATE OF REGISTRATION BY REGISTRAR<br>SEP 14 1982                                                                                                 |  |                                                                                |                                                                                 |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           |                                                                                                                                                             |                                                                        |                                                                  |                                    |                                                                                                                                            |                                            |                                                                   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------|------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|-------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                        |                                                                                                           |                                                                                                                                                             | 2a. DATE OF DEATH                                                      |                                                                  |                                    | 2b. HOUR                                                                                                                                   |                                            |                                                                   |
| FREDERICK B. TALBOTT                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                           |                                                                                                                                                             | September 4 1982                                                       |                                                                  |                                    | 5:45p M                                                                                                                                    |                                            |                                                                   |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                     | 4. RACE                                                                                                   | 5. DATE OF BIRTH                                                                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)                                        |                                                                  |                                    | 7. IF UNDER 1 YEAR                                                                                                                         |                                            |                                                                   |
| Male                                                                                                                                                                                                                                                                                                                                                                                       | White                                                                                                     | Sept. 1, 1913                                                                                                                                               | 69                                                                     |                                                                  |                                    | MONTHS DAYS HOURS MIN.                                                                                                                     |                                            |                                                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                  | 7b. CITIZEN OF WHAT COUNTRY?                                                                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                   |                                                                  |                                    |                                                                                                                                            |                                            |                                                                   |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                   | USA                                                                                                       |                                                                                                                                                             | Baltimore City MD.                                                     |                                                                  |                                    |                                                                                                                                            |                                            |                                                                   |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                             |                                                                        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                    |                                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY          |                                                                   |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                  | Maryland General Hospital                                                                                 |                                                                                                                                                             |                                                                        | Machinist                                                        |                                    |                                                                                                                                            | Industrial                                 |                                                                   |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                           |                                                                                                                                                             | 13b. COUNTY                                                            |                                                                  |                                    | 13c. CITY OR TOWN                                                                                                                          |                                            |                                                                   |
| Md                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                           |                                                                                                                                                             | -                                                                      |                                                                  |                                    | Baltimore                                                                                                                                  |                                            |                                                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                     |                                                                                                           |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                          |                                                                  |                                    |                                                                                                                                            |                                            |                                                                   |
| John W. Talbott                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           |                                                                                                                                                             | Mary S. Wright                                                         |                                                                  |                                    |                                                                                                                                            |                                            |                                                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                       |                                                                                                           |                                                                                                                                                             | 16b. SOCIAL SECURITY NO.                                               |                                                                  |                                    | 17. INFORMANT ADDRESS                                                                                                                      |                                            |                                                                   |
| no                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                           |                                                                                                                                                             | 212 07 4258A                                                           |                                                                  |                                    | Alma May Talbott Same                                                                                                                      |                                            |                                                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                   |                                                                                                           |                                                                                                                                                             |                                                                        |                                                                  |                                    |                                                                                                                                            |                                            | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                   |
| IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>                                                                                                                                                                                                                                                                                                                                              |                                                                                                           |                                                                                                                                                             |                                                                        |                                                                  |                                    |                                                                                                                                            |                                            | 4 minutes                                                         |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Metastatic Colon Carcinoma</u>                                                                                                                                                                                                                                                                                                                    |                                                                                                           |                                                                                                                                                             |                                                                        |                                                                  |                                    |                                                                                                                                            |                                            | 5 months                                                          |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                                                                                                                                                                                                                                                                                                |                                                                                                           |                                                                                                                                                             |                                                                        |                                                                  |                                    |                                                                                                                                            |                                            |                                                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                        |                                                                                                           |                                                                                                                                                             |                                                                        |                                                                  |                                    |                                                                                                                                            |                                            |                                                                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                           |                                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                  |                                    | 20a. AUTOPSY?                                                                                                                              |                                            | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |
|                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           |                                                                                                                                                             |                                                                        |                                                                  |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                                            | YES <input type="checkbox"/> NO <input type="checkbox"/>          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                   |                                                                                                           |                                                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |                                            |                                                                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                               |                                                                                                           |                                                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                  |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                            |                                                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>September 2, 19 82</u> , to <u>September 4 19 82</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>September 4 19 82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did) (did not) view the body after death. |                                                                                                           |                                                                                                                                                             |                                                                        |                                                                  |                                    |                                                                                                                                            |                                            |                                                                   |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                           |                                                                                                                                                             |                                                                        |                                                                  |                                    | DEGREE                                                                                                                                     |                                            | 22c. DATE SIGNED                                                  |
| <u>Lawrence Fitzpatrick M.D.</u>                                                                                                                                                                                                                                                                                                                                                           |                                                                                                           |                                                                                                                                                             |                                                                        |                                                                  |                                    | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                            | 8/4/82                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           |                                                                                                                                                             |                                                                        |                                                                  |                                    | 22e. ADDRESS                                                                                                                               |                                            |                                                                   |
| <u>Lawrence Fitzpatrick M.D.</u>                                                                                                                                                                                                                                                                                                                                                           |                                                                                                           |                                                                                                                                                             |                                                                        |                                                                  |                                    | C/O Maryland General Hospital                                                                                                              |                                            |                                                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                               |                                                                                                           |                                                                                                                                                             | 23b. DATE                                                              |                                                                  | 23c. NAME OF CEMETERY OR CREMATORY |                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |                                                                   |
| Burial                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                           |                                                                                                                                                             | 9/8/82                                                                 |                                                                  | Poplar Grove Cem.                  |                                                                                                                                            | Cockeysville Balto. Co. Md.                |                                                                   |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                           |                                                                                                                                                             |                                                                        |                                                                  |                                    | 25a. DATE REC'D. BY REGISTRAR                                                                                                              |                                            |                                                                   |
| <u>Burgee Funeral Home 3631 Falls Road 21211</u>                                                                                                                                                                                                                                                                                                                                           |                                                                                                           |                                                                                                                                                             |                                                                        |                                                                  |                                    | SEP 7 1982                                                                                                                                 |                                            |                                                                   |
| 25b. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                           |                                                                                                                                                             |                                                                        |                                                                  |                                    |                                                                                                                                            |                                            |                                                                   |
| <u>John J. Conner</u>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           |                                                                                                                                                             |                                                                        |                                                                  |                                    |                                                                                                                                            |                                            |                                                                   |



10/1/50

1943-1944, 1945-1946, 1947-1948, 1949-1950, 1951-1952, 1953-1954, 1955-1956, 1957-1958, 1959-1960, 1961-1962, 1963-1964, 1965-1966, 1967-1968, 1969-1970, 1971-1972, 1973-1974, 1975-1976, 1977-1978, 1979-1980, 1981-1982, 1983-1984, 1985-1986, 1987-1988, 1989-1990, 1991-1992, 1993-1994, 1995-1996, 1997-1998, 1999-2000, 2001-2002, 2003-2004, 2005-2006, 2007-2008, 2009-2010, 2011-2012, 2013-2014, 2015-2016, 2017-2018, 2019-2020, 2021-2022, 2023-2024, 2025-2026, 2027-2028, 2029-2030, 2031-2032, 2033-2034, 2035-2036, 2037-2038, 2039-2040, 2041-2042, 2043-2044, 2045-2046, 2047-2048, 2049-2050, 2051-2052, 2053-2054, 2055-2056, 2057-2058, 2059-2060, 2061-2062, 2063-2064, 2065-2066, 2067-2068, 2069-2070, 2071-2072, 2073-2074, 2075-2076, 2077-2078, 2079-2080, 2081-2082, 2083-2084, 2085-2086, 2087-2088, 2089-2090, 2091-2092, 2093-2094, 2095-2096, 2097-2098, 2099-2100, 2101-2102, 2103-2104, 2105-2106, 2107-2108, 2109-2110, 2111-2112, 2113-2114, 2115-2116, 2117-2118, 2119-2120, 2121-2122, 2123-2124, 2125-2126, 2127-2128, 2129-2130, 2131-2132, 2133-2134, 2135-2136, 2137-2138, 2139-2140, 2141-2142, 2143-2144, 2145-2146, 2147-2148, 2149-2150, 2151-2152, 2153-2154, 2155-2156, 2157-2158, 2159-2160, 2161-2162, 2163-2164, 2165-2166, 2167-2168, 2169-2170, 2171-2172, 2173-2174, 2175-2176, 2177-2178, 2179-2180, 2181-2182, 2183-2184, 2185-2186, 2187-2188, 2189-2190, 2191-2192, 2193-2194, 2195-2196, 2197-2198, 2199-2200, 2201-2202, 2203-2204, 2205-2206, 2207-2208, 2209-2210, 2211-2212, 2213-2214, 2215-2216, 2217-2218, 2219-2220, 2221-2222, 2223-2224, 2225-2226, 2227-2228, 2229-2230, 2231-2232, 2233-2234, 2235-2236, 2237-2238, 2239-2240, 2241-2242, 2243-2244, 2245-2246, 2247-2248, 2249-2250, 2251-2252, 2253-2254, 2255-2256, 2257-2258, 2259-2260, 2261-2262, 2263-2264, 2265-2266, 2267-2268, 2269-2270, 2271-2272, 2273-2274, 2275-2276, 2277-2278, 2279-2280, 2281-2282, 2283-2284, 2285-2286, 2287-2288, 2289-2290, 2291-2292, 2293-2294, 2295-2296, 2297-2298, 2299-2300, 2301-2302, 2303-2304, 2305-2306, 2307-2308, 2309-2310, 2311-2312, 2313-2314, 2315-2316, 2317-2318, 2319-2320, 2321-2322, 2323-2324, 2325-2326, 2327-2328, 2329-2330, 2331-2332, 2333-2334, 2335-2336, 2337-2338, 2339-2340, 2341-2342, 2343-2344, 2345-2346, 2347-2348, 2349-2350, 2351-2352, 2353-2354, 2355-2356, 2357-2358, 2359-2360, 2361-2362, 2363-2364, 2365-2366, 2367-2368, 2369-2370, 2371-2372, 2373-2374, 2375-2376, 2377-2378, 2379-2380, 2381-2382, 2383-2384, 2385-2386, 2387-2388, 2389-2390, 2391-2392, 2393-2394, 2395-2396, 2397-2398, 2399-2400, 2401-2402, 2403-2404, 2405-2406, 2407-2408, 2409-2410, 2411-2412, 2413-2414, 2415-2416, 2417-2418, 2419-2420, 2421-2422, 2423-2424, 2425-2426, 2427-2428, 2429-2430, 2431-2432, 2433-2434, 2435-2436, 2437-2438, 2439-2440, 2441-2442, 2443-2444, 2445-2446, 2447-2448, 2449-2450, 2451-2452, 2453-2454, 2455-2456, 2457-2458, 2459-2460, 2461-2462, 2463-2464, 2465-2466, 2467-2468, 2469-2470, 2471-2472, 2473-2474, 2475-2476, 2477-2478, 2479-2480, 2481-2482, 2483-2484, 2485-2486, 2487-2488, 2489-2490, 2491-2492, 2493-2494, 2495-2496, 2497-2498, 2499-2500, 2501-2502, 2503-2504, 2505-2506, 2507-2508, 2509-2510, 2511-2512, 2513-2514, 2515-2516, 2517-2518, 2519-2520, 2521-2522, 2523-2524, 2525-2526, 2527-2528, 2529-2530, 2531-2532, 2533-2534, 2535-2536, 2537-2538, 2539-2540, 2541-2542, 2543-2544, 2545-2546, 2547-2548, 2549-2550, 2551-2552, 2553-2554, 2555-2556, 2557-2558, 2559-2560, 2561-2562, 2563-2564, 2565-2566, 2567-2568, 2569-2570, 2571-2572, 2573-2574, 2575-2576, 2577-2578, 2579-2580, 2581-2582, 2583-2584, 2585-2586, 2587-2588, 2589-2590, 2591-2592, 2593-2594, 2595-2596, 2597-2598, 2599-2600, 2601-2602, 2603-2604, 2605-2606, 2607-2608, 2609-2610, 2611-2612, 2613-2614, 2615-2616, 2617-2618, 2619-2620, 2621-2622, 2623-2624, 2625-2626, 2627-2628, 2629-2630, 2631-2632, 2633-2634, 2635-2636, 2637-2638, 2639-2640, 2641-2642, 2643-2644, 2645-2646, 2647-2648, 2649-2650, 2651-2652, 2653-2654, 2655-2656, 2657-2658, 2659-2660, 2661-2662, 2663-2664, 2665-2666, 2667-2668, 2669-2670, 2671-2672, 2673-2674, 2675-2676, 2677-2678, 2679-2680, 2681-2682, 2683-2684, 2685-2686, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                                                                            |                                                                                                    |                                                                                                 |                                |                                                                                                                            |                                              |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CHARLES V. TANKERSLEY</b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                             |                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR <b>9 22 82</b>                                                                                            |                                                                                                    |                                                                                                 |                                |                                                                                                                            | 2b. HOUR <b>7:20 PM</b>                      |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br><b>White</b>                                                                                                                     |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 1, 1906</b>                                                                                                   |                                                                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.                                                  |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS |                                                                                                                            | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                               |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE, CITY</b> MD.                                 |                                                                                                 |                                |                                                                                                                            |                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |                                                                        |                                                                                                                                                             |                                                                                                                                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supervisor Acme Markets</b> |                                                                                                 |                                | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                              |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                             | 13b. COUNTY                                                            |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                      |                                                                                                    | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                | 13e. STREET ADDRESS<br><b>1017 Upnor Road 21212</b>                                                                        |                                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles C. Tankersley</b>                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                             |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sallie W. Phoebus</b>                                                                                   |                                                                                                                                            |                                                                                                    |                                                                                                 |                                |                                                                                                                            |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br><b>WW II 215-10-7540</b>                   |                                                                                                                                                             | 17. INFORMANT ADDRESS<br><b>Stella Tankersley 1017 Upnor Rd. 21212</b>                                                                     |                                                                                                    |                                                                                                 |                                |                                                                                                                            |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b><br>4149<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ISCHEMIC Heart Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>years</b> |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                                                                            |                                                                                                    |                                                                                                 |                                |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                     |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                                                                            |                                                                                                    |                                                                                                 |                                |                                                                                                                            |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                                                                            |                                                                                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                |  |                                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |                                                                                                    |                                                                                                 |                                |                                                                                                                            |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                          |  |                                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                                                    |                                                                                                 |                                |                                                                                                                            |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/17 19 82</b> , to <b>9/22 19 82</b> , that (I) (we) last saw the deceased alive on <b>9/22 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.                                                                  |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                                                                            |                                                                                                    |                                                                                                 |                                |                                                                                                                            |                                              |  |
| 22b. SIGNATURE<br><b>David C. Allen</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                             | DEGREE<br><b>MD</b>                                                    |                                                                                                                                                             | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                    |                                                                                                 |                                | 22c. DATE SIGNED<br><b>9/22/82</b>                                                                                         |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DAVID C. ALLEN, M.D.</b>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                             |                                                                        |                                                                                                                                                             | 22e. ADDRESS<br><b>U.M.H. 201 E. UNIVERSITY PKWY. #21218</b>                                                                               |                                                                                                    |                                                                                                 |                                |                                                                                                                            |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                             | 23b. DATE<br><b>SEP 25 1982</b>                                        |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial</b>                                                                             |                                                                                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |                                |                                                                                                                            |                                              |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                             |                                                                        |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 23 1982</b>                                                                                        |                                                                                                    | 25b. REGISTRAR'S SIGNATURE<br><b>Joan J. Connel</b>                                             |                                |                                                                                                                            |                                              |  |

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FILE

Item #1 Film G571 9/16/82 rc

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 5 3 6

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                               |                                                                                                                                                             |                                                                                                    |                                                                                                               |                                                                                                                                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Lillington Charles Tauber</b><br><b>Charles</b>                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                               |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>September 8, 1982</b>                                       |                                                                                                               | 2b. HOUR<br><b>4:58P M</b>                                                                                                               |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 4. RACE<br><b>White</b>                                                                                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 22, 1909</b>                                                                                                  |                                                                                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.                                                             | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                                          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                 | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                  |                                                                                                               |                                                                                                                                          |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Motion Picture Operator</b> |                                                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                        |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                               | 13b. COUNTY<br><b>BALTO</b>                                                                                                                                 | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                              | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>6824 Old Pimlico Rd. 21209</b>                                                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles H. Tauber</b>                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Leona Parker</b>                                                                                        |                                                                                                    |                                                                                                               |                                                                                                                                          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                               | 16b. SOCIAL SECURITY NO.<br><b>216-10-0022</b>                                                                                                              |                                                                                                    | 17. INFORMANT ADDRESS<br><b>Mrs. Filena M. Miller 1309 E 36th St.</b>                                         |                                                                                                                                          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                                                                                                                  |                                                                                                                                               |                                                                                                                                                             |                                                                                                    |                                                                                                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Multiple CerebroVascular Accidents</b>                                                                                                                                                                                                                                                                                                |                                                                                                                                               |                                                                                                                                                             |                                                                                                    |                                                                                                               |                                                                                                                                          |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                    | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                  |                                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                |                                                                                                                                          |
| 21d. INJURY OCCURRED<br><input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                             |                                                                                                                                          |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 25, 1982</b> to <b>September 8, 1982</b> , that <input checked="" type="checkbox"/> (we) lost <input type="checkbox"/> saw the deceased alive on <b>September 8, 1982</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (If not, state in brief the cause of death.) |                                                                                                                                               |                                                                                                                                                             |                                                                                                    |                                                                                                               |                                                                                                                                          |
| 22b. SIGNATURE<br><b>K. Kassler-Taubman</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                               | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                                                                                    | 22c. DATE SIGNED<br><b>9/8/82</b>                                                                             |                                                                                                                                          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>K. Kassler-Taubman</b>                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                               | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>                                                                                                        |                                                                                                    |                                                                                                               |                                                                                                                                          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Entombment</b>                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                               | 23b. DATE<br><b>Sept 11 1982</b>                                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>                                  |                                                                                                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                                                                  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                               |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 10 1982</b>                                                |                                                                                                               | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                                                                      |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                            |  |  |  |  | 8 2 2 3 5 3 7<br>REG. NO.                                                                                                                                      |  |  |  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                          |  |  |  |  |                                                                                                                                                                |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Charles Taylor</i>                                                                                                                                                                                                                                                                     |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>9 24 82</i>                                                                                                             |  |  |  |  |
| 3 SEX<br><i>Male</i>                                                                                                                                                                                                                                                                                                                            |  |  |  |  | 4 RACE<br><i>Black</i>                                                                                                                                         |  |  |  |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br><i>3 27 1908</i>                                                                                                                                                                                                                                                                                             |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>74</i> YRS                                                                                                               |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><i>Virginia</i>                                                                                                                                                                                                                                                                                            |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                                                  |  |  |  |  |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                      |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Balto. City</i> MD.                                                                                                 |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>                                                                                                                                                                                                                                                                                                   |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><i>Lutheran Hosp.</i>                                                                               |  |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Crane-Operator</i>                                                                                                                                                                                                                                                          |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>American Smelting</i>                                                                                                  |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><i>Md</i>                                                                                                                                                                                                                                       |  |  |  |  | 13b. COUNTY<br><i>Balto.</i>                                                                                                                                   |  |  |  |  |
| 13c. CITY OR TOWN<br><i>Balto.</i>                                                                                                                                                                                                                                                                                                              |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                |  |  |  |  |
| 13e. STREET ADDRESS<br><i>3027 Westwood Ave</i>                                                                                                                                                                                                                                                                                                 |  |  |  |  | 13f. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Balto. City</i> MD.                                                                                               |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Willie Taylor</i>                                                                                                                                                                                                                                                                                     |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Henrietta Jones</i>                                                                                           |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>No</i>                                                                                                                                                                                                                                                                  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br><i>212-10-1066</i>                                                                                                                 |  |  |  |  |
| 17. INFORMATION<br><i>Baltimore, Maryland 21216</i>                                                                                                                                                                                                                                                                                             |  |  |  |  | 17b. ADDRESS<br><i>Mrs. Susie Taylor 3027 Westwood Ave.</i>                                                                                                    |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>RESPIRATORY FAILURE</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>CARCINOMA OF LUNG</i>                                                          |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                             |  |  |  |  |                                                                                                                                                                |  |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                          |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                               |  |  |  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                       |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                     |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                        |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>                                                                                              |  |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                                                                                                                                  |  |  |  |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |  |  |  |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                                          |  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9. 21. 19 82</i> to <i>9. 24. 19 82</i> , that (I) (we) lost<br>saw the deceased alive on <i>9. 24. 19 82</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |                                                                                                                                                                |  |  |  |  |
| 22b. SIGNATURE<br><i>N.S. ASHOK</i>                                                                                                                                                                                                                                                                                                             |  |  |  |  | 22c. DATE SIGNED                                                                                                                                               |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>N.S. ASHOK</i>                                                                                                                                                                                                                                                                                      |  |  |  |  | 22e. ADDRESS<br><i>Lutheran Hospital</i>                                                                                                                       |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>                                                                                                                                                                                                                                                                                      |  |  |  |  | 23b. DATE<br><i>9/29/82</i>                                                                                                                                    |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Olive Cemetery</i>                                                                                                                                                                                                                                                                                 |  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Northumberland Co, Virginia</i>                                                                               |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><i>HERBERT E. NATTEL FUNERAL HOME</i>                                                                                                                                                                                                                                                                              |  |  |  |  | 25a. DATE RECEIVED BY REGISTRAR<br><i>SEP 30 1982</i>                                                                                                          |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>John J. Connel</i>                                                                                                                                                                                                                                                                                             |  |  |  |  |                                                                                                                                                                |  |  |  |  |





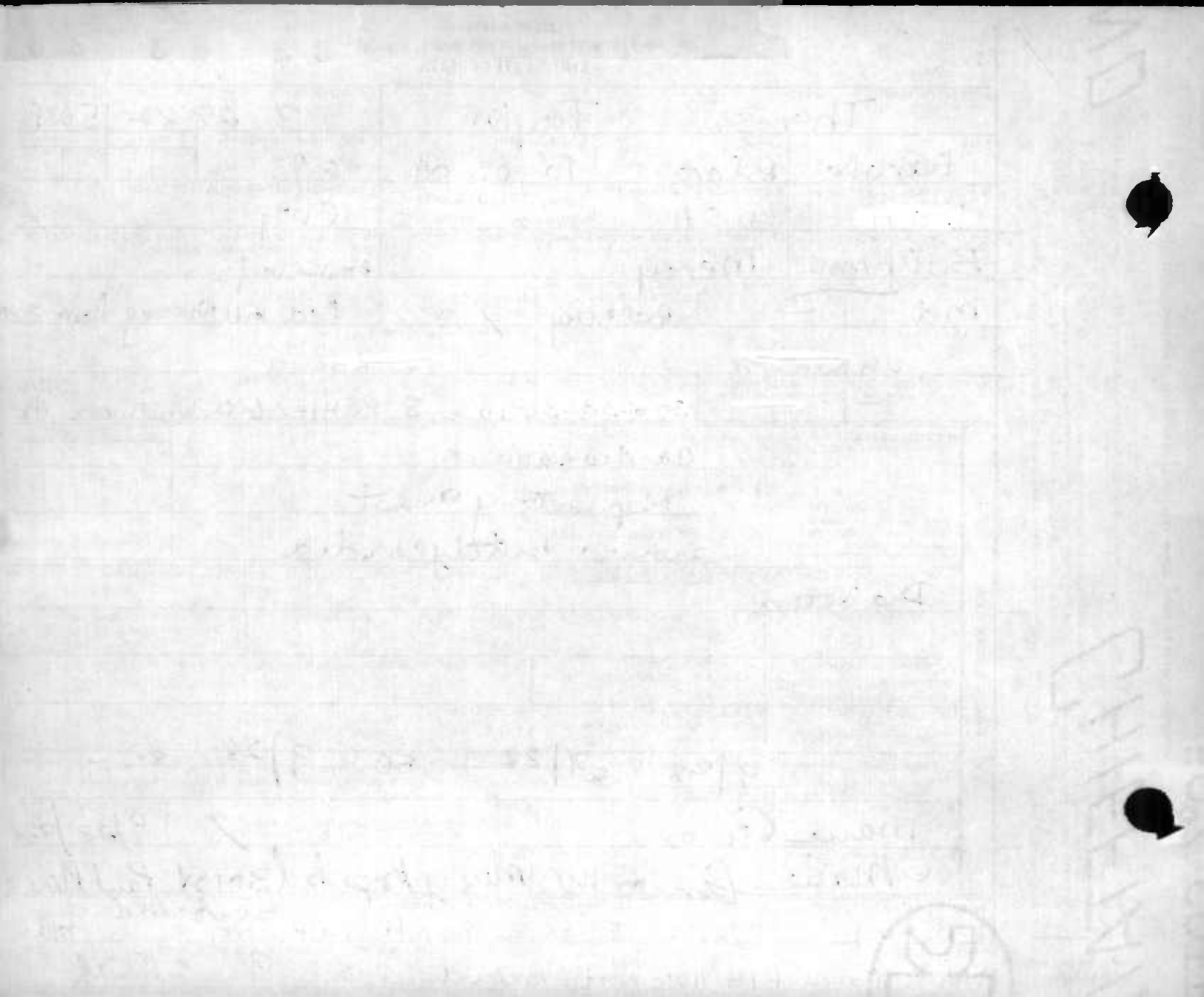
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 11 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                     |                                                                                                        |                                                                                                                                                                                                                  |                                                                     | 8 2 2 3 5 3 8                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                   |                                                                                                        | REG. NO.                                                                                                                                                                                                         |                                                                     |                                |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                         |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                                                                                |                                                                     | 2b. HOUR                       |
| FIRST MIDDLE LAST<br>Theresa Taylor                                                                                                                                                                                                                                                                                                                      |                                                                                                        | MONTH DAY YEAR<br>9 28 82                                                                                                                                                                                        |                                                                     | 5:03 PM                        |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                   | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | IF UNDER 1 YEAR<br>MONTHS DAYS |
| Female                                                                                                                                                                                                                                                                                                                                                   | Black                                                                                                  | MONTH DAY YEAR<br>10 03 09                                                                                                                                                                                       | 8 73 YRS.                                                           | IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                |
| USA                                                                                                                                                                                                                                                                                                                                                      | U.S.A                                                                                                  |                                                                                                                                                                                                                  | City MD.                                                            |                                |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                                                                                    | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                                |
| Baltimore                                                                                                                                                                                                                                                                                                                                                | Mercy                                                                                                  | housewife                                                                                                                                                                                                        |                                                                     |                                |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                               | 13b. COUNTY                                                                                            | 13c. CITY OR TOWN                                                                                                                                                                                                | 13d. INSIDE CITY LIMITS?                                            | 13e. STREET ADDRESS            |
| md                                                                                                                                                                                                                                                                                                                                                       |                                                                                                        | Baltimore                                                                                                                                                                                                        | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | Fed Hill Nursing Home 2120     |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                        | 15. MOTHER'S MAIDEN NAME                                                                               | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                |                                                                     |                                |
| Unknown                                                                                                                                                                                                                                                                                                                                                  | Unknown                                                                                                | 16b. SOCIAL SECURITY NO. 219-22-8691                                                                                                                                                                             |                                                                     |                                |
| 17. INFORMANT                                                                                                                                                                                                                                                                                                                                            |                                                                                                        | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                        |                                                                     |                                |
| Renee S. Battle 600 Whitmore Ave 21216                                                                                                                                                                                                                                                                                                                   |                                                                                                        | PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiac arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>Respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <u>sinus bradycardia</u> |                                                                     |                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes</u>                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                                                                                  |                                                                     |                                |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       | 20a. AUTOPSY?                                                                                                                                                                                                    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                                |
|                                                                                                                                                                                                                                                                                                                                                          |                                                                                                        | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                         | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                        | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                                                                                    |                                                                     |                                |
|                                                                                                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                                                                                  |                                                                     |                                |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK                                                                                                                                                                                                                                                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                   |                                                                     |                                |
|                                                                                                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                                                                                  |                                                                     |                                |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/28</u> 19 <u>82</u> to <u>9/28</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>9/28</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                        |                                                                                                                                                                                                                  |                                                                     |                                |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                           |                                                                                                        | DEGREE                                                                                                                                                                                                           |                                                                     | 22c. DATE SIGNED               |
| Maue Amos                                                                                                                                                                                                                                                                                                                                                |                                                                                                        |                                                                                                                                                                                                                  |                                                                     | 9/28/82                        |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                    |                                                                                                        | 22e. ADDRESS                                                                                                                                                                                                     |                                                                     |                                |
| Maue Amos MD                                                                                                                                                                                                                                                                                                                                             |                                                                                                        | Mercy Hospital 301 St. Paul Place                                                                                                                                                                                |                                                                     |                                |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                | 23b. DATE                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                                                                               | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |                                |
| Burial                                                                                                                                                                                                                                                                                                                                                   | 10/2/82                                                                                                | Eastview Mem PK                                                                                                                                                                                                  | Balt. Md                                                            | md                             |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                |                                                                                                        | 25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE                                                                                                                                                          |                                                                     |                                |
| Wm C. March F I H 1101 E North Avenue                                                                                                                                                                                                                                                                                                                    |                                                                                                        | OCT 1 1982 Jan J. Connel                                                                                                                                                                                         |                                                                     |                                |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

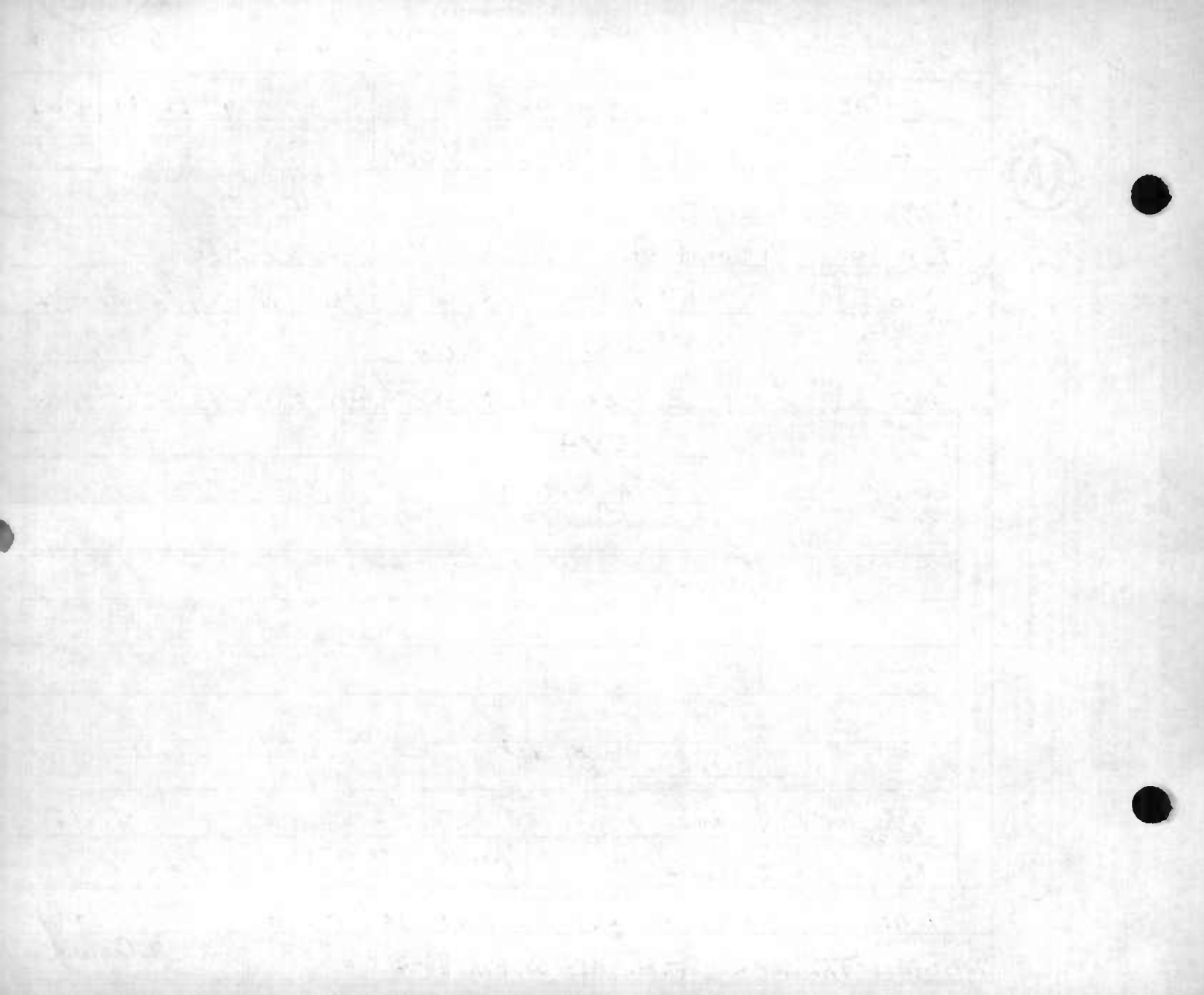
8 2 2 3 5 3 9

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                      |                                                                                                                                                            |                                                                                                                               |                                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>BESSIE S. THOMAS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                      | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 22 82</b>                                                                                                       |                                                                                                                               | 2b HOUR<br><b>5:00a M</b>                                       |
| 3 SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 4 RACE<br><b>Black</b>                                                                                                                               | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11-25-1901</b>                                                                                                     | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS                                                                               | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 72 HRS<br>HOURS MIN. |
| 7 BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                            | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALT. CITY</b> MD.                                                                  |                                                                 |
| 10 CITY OR TOWN OF DEATH<br><b>Balto.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PROVIDENT HOSPITAL</b>               | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                                                                        | 12b KIND OF BUSINESS OR INDUSTRY                                                                                              |                                                                 |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 13b. COUNTY                                                                                                                                          | 13c. CITY OR TOWN<br><b>Balto</b>                                                                                                                          | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               | 13e. STREET ADDRESS<br><b>1611 N. Gilmore St</b>                |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>? HOWARD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LUCY SMITH</b>                                                                                    |                                                                                                                                                            | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>                                                 |                                                                 |
| 16b SOCIAL SECURITY NO.<br><b>217-22-6081</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                      | 17 INFORMANT<br><b>MORRO HAWKINS</b> ADDRESS<br><b>2405 Hermosa</b>                                                                                        |                                                                                                                               |                                                                 |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4360</b> IMMEDIATE CAUSE (a) <b>CVA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HYPERTENSION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Septicemia</b> |                                                                                                                                                      |                                                                                                                                                            |                                                                                                                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                                                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                             |                                                                                                                               |                                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                 | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                          |                                                                                                                               |                                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/24/82</b> , 19 <b>82</b> , to <b>9/22/82</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>9/22/82</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                               |                                                                                                                                                      |                                                                                                                                                            |                                                                                                                               |                                                                 |
| 22b. SIGNATURE<br><b>Nigel E.R. Jackman M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                                                                            | 22c. DATE SIGNED<br><b>9/22/82</b>                                                                                            |                                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NIGEL E.R. JACKMAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 22e. ADDRESS<br><b>PROVIDENT HOSPITAL<br/>2600, Liberty Heights Balt. Md</b>                                                                         |                                                                                                                                                            |                                                                                                                               |                                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 23b. DATE<br><b>9-28-82</b>                                                                                                                          | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>                                                                                              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto MD</b>                                                                 |                                                                 |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>BROWN-THOMPSON F.H.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ADDRESS<br><b>1913 W. Balto</b>                                                                                                                      | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 23 1982</b>                                                                                                        |                                                                                                                               |                                                                 |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canine</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                      |                                                                                                                                                            |                                                                                                                               |                                                                 |

MEDICAL CERTIFICATION



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 5 4 0

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                            |                                            |                                                                                                                                                             |                                                                  |                                                                                                 |                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JAKE R. THOMAS</b>                                                                                                                                                                                                                                                                                                                                                  |                                            |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>SEPTEMBER 21, 1982</b> |                                                                                                 | 2b. HOUR<br><b>11:17p</b> |
| 1. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                      | 4. RACE<br><b>Black</b>                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 25 12</b>                                                                                                       |                                                                  | 6. AGE (IN YEARS, LAST BIRTHDAY)<br><b>69 YRS</b>                                               |                           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. Carolina</b>                                                                                                                                                                                                                                                                                                                                            | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |                           |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                              |                                            | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b>                  |                                                                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |                           |
| 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                                                          |                                            |                                                                                                                                                             |                                                                  |                                                                                                 |                           |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                              |                                            | 13b. COUNTY                                                                                                                                                 | 13c. CITY OR TOWN<br><b>Baltimore</b>                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                           |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jack Thomas</b>                                                                                                                                                                                                                                                                                                                                               |                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Fannie Booker</b>                                                                                       |                                                                  | 16. STREET ADDRESS<br><b>1808 E. 29th Street</b>                                                |                           |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                              |                                            | 17b. SOCIAL SECURITY NO.<br><b>237-03-7651</b>                                                                                                              |                                                                  | 17. INFORMANT<br><b>James Thomas 6616 Eberle Drive</b>                                          |                           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br><b>2041</b> IMMEDIATE CAUSE (a) <b>respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>chronic lymphocytic leukemia</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 min</b><br><b>2 wks</b><br><b>5 yrs</b> |                                            |                                                                                                                                                             |                                                                  |                                                                                                 |                           |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:8                                                                                                                                                                                                                                                                          |                                            |                                                                                                                                                             |                                                                  |                                                                                                 |                           |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                     |                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                           |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                 |                                            |                                                                                                                                                             |                                                                  |                                                                                                 |                           |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                   |                                            | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                           |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                  |                                            | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                           |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/7</b> , 19 <b>82</b> , to <b>9/21</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>9/21</b> , 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                            |                                            |                                                                                                                                                             |                                                                  |                                                                                                 |                           |
| 22b. SIGNATURE<br><b>R A Lange M.D.</b>                                                                                                                                                                                                                                                                                                                                                                    |                                            | DEGREE<br><b>MD</b>                                                                                                                                         |                                                                  | 22c. DATE SIGNED<br><b>9/21/82</b>                                                              |                           |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R A LANGE M.D.</b>                                                                                                                                                                                                                                                                                                                                             |                                            | 22e. ADDRESS<br><b>Johns Hopkins Hosp</b>                                                                                                                   |                                                                  |                                                                                                 |                           |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                              |                                            | 23b. DATE<br><b>9/25/82</b>                                                                                                                                 |                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Auburn Cem</b>                                   |                           |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                          |                                            | COUNTY<br><b>Md.</b>                                                                                                                                        |                                                                  | 23e. STATE                                                                                      |                           |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Avenue</b>                                                                                                                                                                                                                                                                                                                               |                                            | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 23 1982</b>                                                                                                         |                                                                  |                                                                                                 |                           |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>                                                                                                                                                                                                                                                                                                                                                        |                                            |                                                                                                                                                             |                                                                  |                                                                                                 |                           |

SECTION 201 (a) (1) (A)

SECTION 201 (a) (1) (B)

UNITED STATES OF AMERICA  
DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535





P1007

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

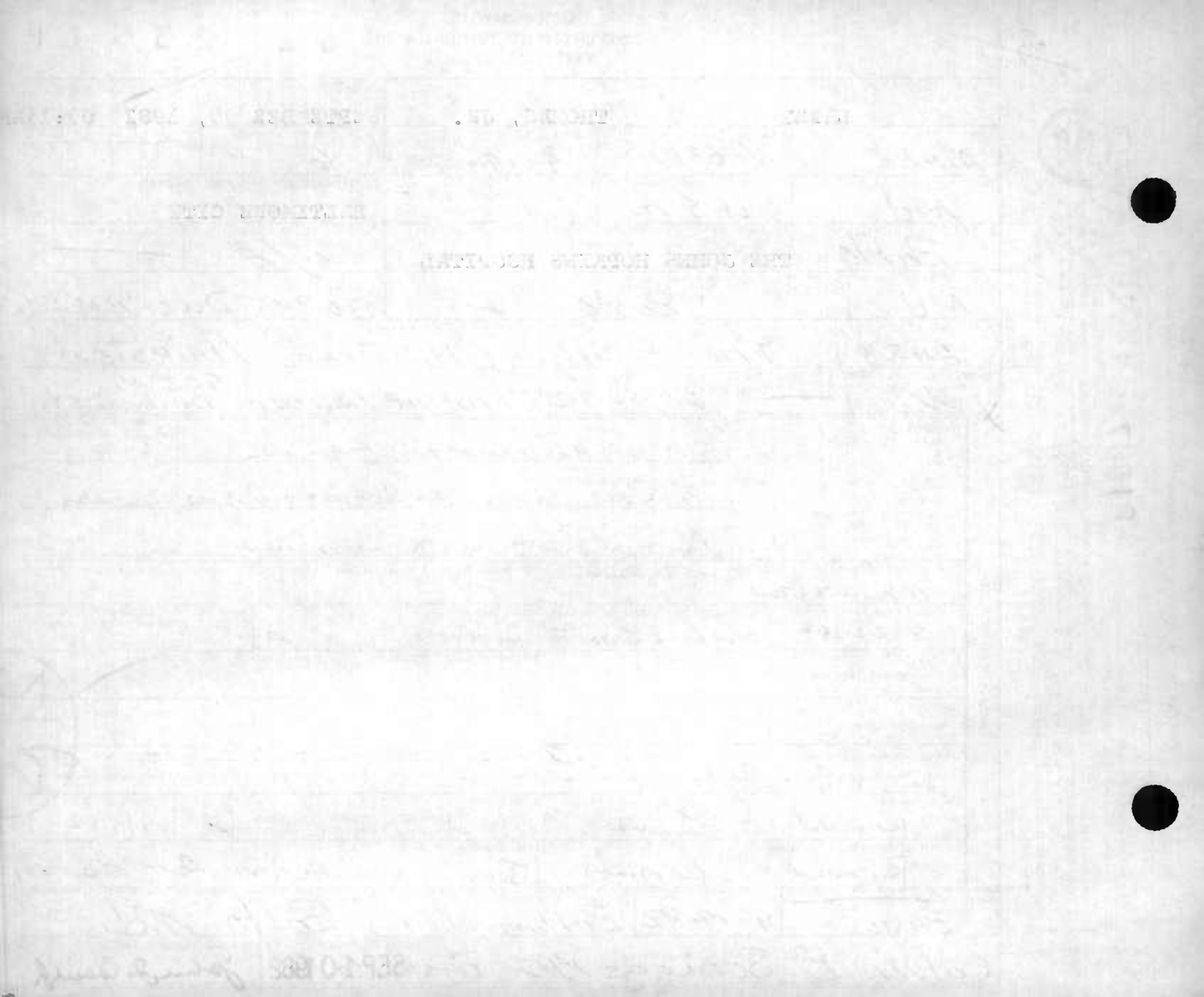
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

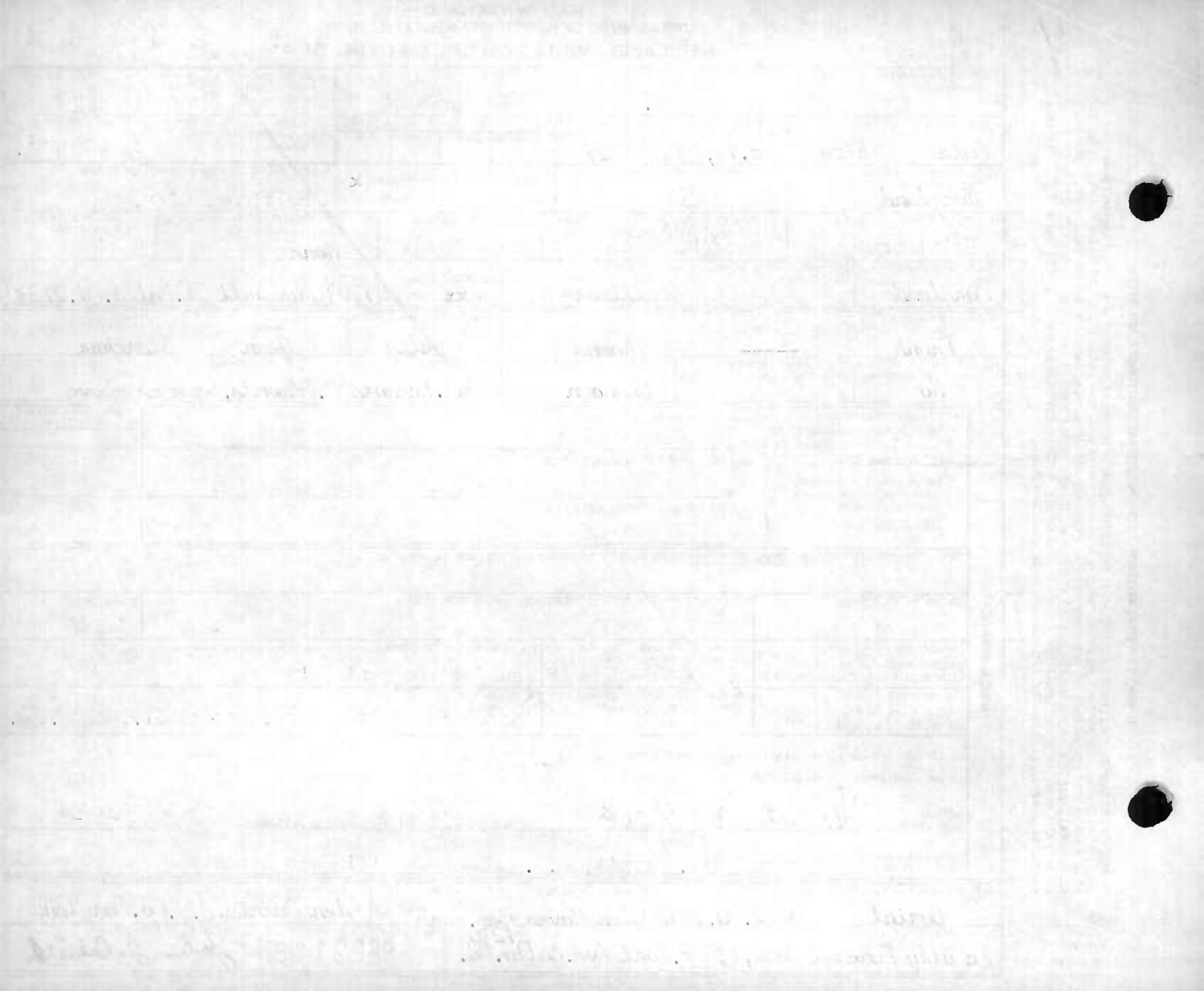
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                               |                                               |                                                                                                                                                             |  | 8 2 2 3 5 4 1<br>REG. NO.                                                                                                                            |                                    |                                                                                                                            |  |                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|-----------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LARRY THOMAS, JR.</b>                                                                                                                                                                                                                                                                                                                                                                    |                                               |                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>SEPTEMBER 09, 1982</b>                                                                                     |                                    |                                                                                                                            |  | 2b. HOUR<br><b>09:11 AM</b> |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                              | 4. RACE<br><b>NEGROID</b>                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9-19-75</b>                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>6</b> YRS                                                                                                      |                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |  |                             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                                            | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                                                                                    |                                    |                                                                                                                            |  |                             |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>                                                                                                                                                                                                                                                                                                                                                                                         |                                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b>              |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>N/A</b>                                                                       |                                    | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |                             |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                |                                               |                                                                                                                                                             |  | 13b. COUNTY<br><b>Balto.</b>                                                                                                                         | 13c. CITY OR TOWN<br><b>Balto.</b> | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |                             |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LARRY THOMAS Sr.</b>                                                                                                                                                                                                                                                                                                                                                                  |                                               |                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CHRISTINE HAIRSTON</b>                                                                           |                                    |                                                                                                                            |  |                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                  |                                               | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219-82-3125</b>                                                                               |  | 17. INFORMANT<br>ADDRESS<br><b>Christine Hairston 903 N. Durham St.</b>                                                                              |                                    |                                                                                                                            |  |                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>2050</b> IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PROBABLE SEPSIS AND PULMONARY DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ACUTE MONONUCLEOTIC LEUKEMIA</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hr.</b><br><b>3 weeks</b> |                                               |                                                                                                                                                             |  |                                                                                                                                                      |                                    |                                                                                                                            |  |                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.<br><b>MALNUTRITION</b>                                                                                                                                                                                                                                                                         |                                               |                                                                                                                                                             |  |                                                                                                                                                      |                                    |                                                                                                                            |  |                             |
| 19a. DATE OF OPERATION<br><b>8/22/82</b>                                                                                                                                                                                                                                                                                                                                                                                           |                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>OPEN LUNG Biopsy For Diagnosis</b>                                                                   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                 |                                    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                           |                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |                                    |                                                                                                                            |  |                             |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                       |                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |                                    |                                                                                                                            |  |                             |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>0800</b> , 19 <b>82</b> , to <b>919</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>919</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                   |                                               |                                                                                                                                                             |  |                                                                                                                                                      |                                    |                                                                                                                            |  |                             |
| 22b. SIGNATURE<br><b>Richard S. Lemons</b>                                                                                                                                                                                                                                                                                                                                                                                         |                                               |                                                                                                                                                             |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                    | 22c. DATE SIGNED<br><b>9/9/82</b>                                                                                          |  |                             |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RICHARD S. LEMONS</b>                                                                                                                                                                                                                                                                                                                                                                  |                                               |                                                                                                                                                             |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL DEPT. ROYALTY</b>                                                                                          |                                    |                                                                                                                            |  |                             |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                         |                                               | 23b. DATE<br><b>9-14-82</b>                                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cem.</b>                                                                                          |                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. MD.</b>                                                            |  |                             |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Calvin B. Scruggs</b>                                                                                                                                                                                                                                                                                                                                                                           |                                               |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 10 1982</b>                                                                                                  |                                    | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canine</b>                                                                        |  |                             |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                     |  |                                                                                                                                                          |  |                                                                                                       |  |                                                                                  |  | REG. NO. 2 2 3 5 4 2                         |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                     |  |                                                                                                                                                          |  |                                                                                                       |  |                                                                                  |  |                                              |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) Nathan R. Thomas                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                     |  |                                                                                                                                                          |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 9 16 1982                    |  | 2b. HOUR M 6:38 A.M.                                                             |  |                                              |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br>White                                                                                                                    |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR Oct. 18, 1960                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>21 YRS.                                                            |  | 7. IF UNDER 1 YR. MONTHS DAYS                                                    |  | 7c. DATE PRONOUNCED DEAD 9 16 1982           |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                 |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                           |  |                                                                                  |  |                                              |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland Penitentiary |  |                                                                                                                                                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>None                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                |  |                                              |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 13b. COUNTY                                                                                                                         |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                           |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |  | 13e. STREET ADDRESS<br>1703 Marshall St. Balto. Md. 21230                        |  |                                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST Frank Thomas                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST Betty Jean Starcken                                                                                        |  |                                                                                                       |  |                                                                                  |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) No                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.<br>Unknown                                                                                                                      |  | 17. INFORMANT ADDRESS<br>Mrs. Leenora M. Edmonds, Same as above                                       |  |                                                                                  |  |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hanging<br>9530<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                                                                             |  |                                                                                                                                     |  |                                                                                                                                                          |  |                                                                                                       |  |                                                                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                     |  |                                                                                                                                                          |  |                                                                                                       |  |                                                                                  |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                        |  |                                                                                                       |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                              |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR ? P.M. 9 16 1982                                                                                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject hung himself |  |                                                                                  |  |                                              |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>Jail                                                                                      |  | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Maryland Penitentiary, Forrest St., Balto., Md.  |  |                                                                                  |  |                                              |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                                                                                                                                     |  |                                                                                                                                                          |  |                                                                                                       |  |                                                                                  |  |                                              |  |
| ACTUAL SIGNATURE<br>Margie A. Korell                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                     |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER                                                                                                       |  |                                                                                                       |  | DATE SIGNED<br>9-16-82                                                           |  |                                              |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) Margarita A. Korell, M.D.                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                     |  | ADDRESS<br>111 Penn Street                                                                                                                               |  |                                                                                                       |  |                                                                                  |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) Burial                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                     |  | 23b. DATE<br>Sept. 20, 1982                                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem Park                                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie, A.A. Co. Maryland     |  |                                              |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>McCully Funeral Home, 130 E. Fort Ave. Balto. Md.                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                     |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 21 1982                                                                                                             |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Canine                                                          |  |                                                                                  |  |                                              |  |

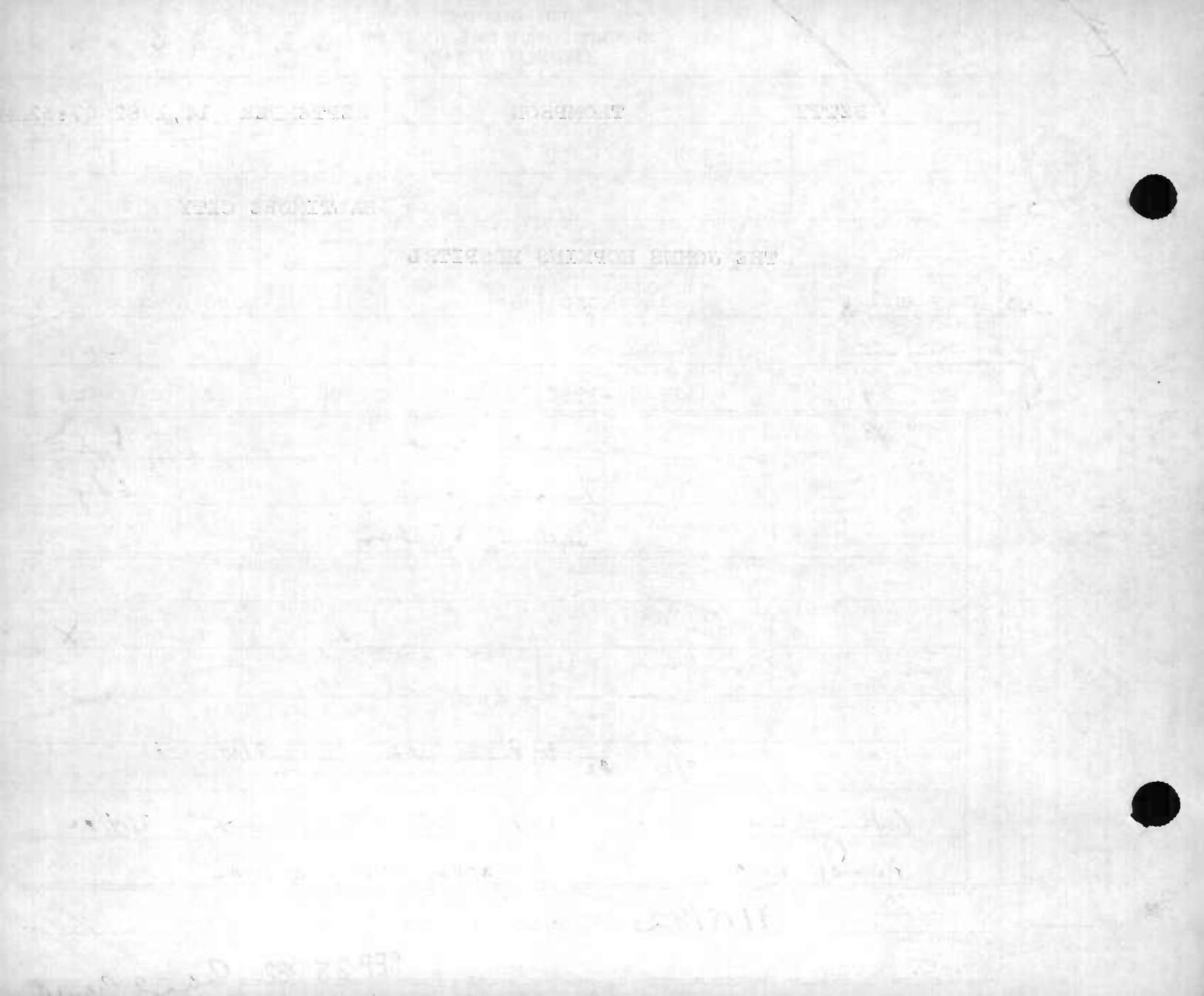


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                |  | REG. NO. 8 2 2 3 5 4 3                                                                                                                                   |  |                                                                                                                                       |                                                                                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BETTY THOMPSON</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>SEPTEMBER 14, 1982</b>                                                                                            |  |                                                                                                                                       |                                                                                   |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                |  | 4. RACE<br><b>Black</b>                                                                                                                                  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 12 31</b>                                                                                 |                                                                                   |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                     |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                                     |                                                                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |                                                                                                                                                          |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                      |                                                                                   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                        |  | 13b. COUNTY                                                                                                                                    |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |                                                                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Walter Thompson</b>                                                                                                                                                                                                                                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ruth Seaborn</b>                                                                           |  |                                                                                                                                                          |  |                                                                                                                                       |                                                                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br><b>023-24-1990</b>                                                                                                 |  | 17. INFORMANT ADDRESS<br><b>Walter Thompson 3813 Oakford Apt E</b>                                                                                       |  |                                                                                                                                       |                                                                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u><br><b>7101</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Respiratory failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Systemic Sclerosis</u> |  |                                                                                                                                                |  |                                                                                                                                                          |  |                                                                                                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 minutes</b><br><b>6 days</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                |  |                                                                                                                                                          |  |                                                                                                                                       |                                                                                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                               |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                                                                                       |                                                                                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                        |  |                                                                                                                                       |                                                                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/8</u> , 19 <u>82</u> , to <u>9/14</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>9/14</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                    |  |                                                                                                                                                |  |                                                                                                                                                          |  |                                                                                                                                       |                                                                                   |
| 22b. SIGNATURE<br><u>Anthony Elias</u>                                                                                                                                                                                                                                                                                                                                                                               |  | DEGREE<br><u>MD</u>                                                                                                                            |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED<br><u>9/14/82</u>                                                                                                    |                                                                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>ANTHONY ELIAS</u>                                                                                                                                                                                                                                                                                                                                                        |  | 22e. ADDRESS<br><u>JOHNS HOPKINS HOSPITAL</u>                                                                                                  |  |                                                                                                                                                          |  |                                                                                                                                       |                                                                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                           |  | 23b. DATE<br><b>9/18/82</b>                                                                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial</b>                                                                                            |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus Md.</b>                                                                      |                                                                                   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Avenue</b>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>SEP 23 1982</b> <u>John G. P.</u>                                                         |  |                                                                                                                                       |                                                                                   |



Items #2a&6 Film G571 9/15/82 re  
 FOR  
 1- STATE  
 REGISTRAR  
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

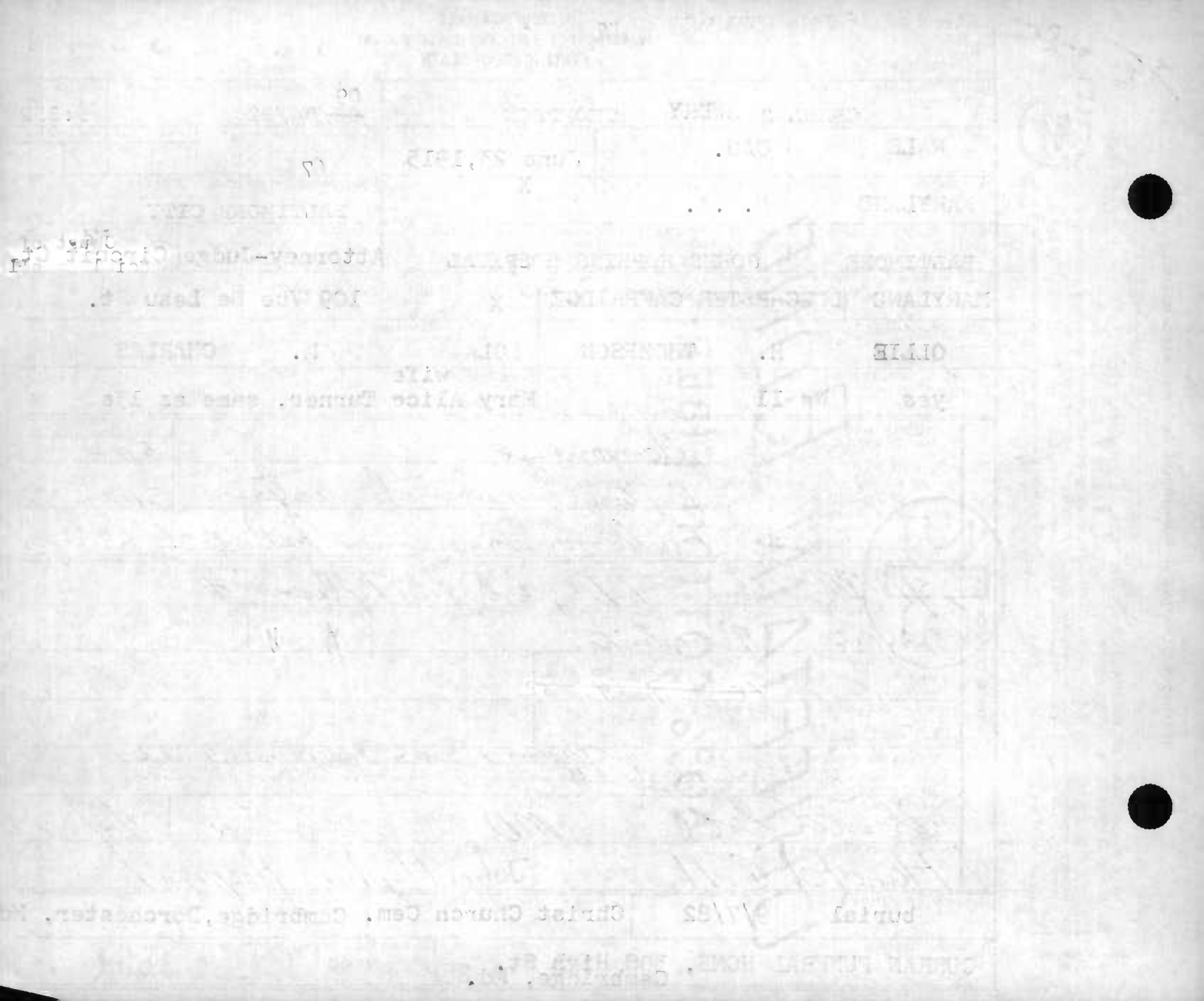
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 REG. NO.

|                                                                                                                                                                                                                                                                                                                                                               |                                                                                                           |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                |                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|-------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                           |                                                                                                           | FIRST MIDDLE LAST                                                                                                                                           |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                           |  | 2b. HOUR                                                       |                                                 |
| CHARLES AWDRY THOMPSON                                                                                                                                                                                                                                                                                                                                        |                                                                                                           |                                                                                                                                                             |  | 08/04/82                                                                                                                                   |  | 9:35P                                                          |                                                 |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                        | 4. RACE                                                                                                   | 5. DATE OF BIRTH                                                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                                            |  | IF UNDER 1 YEAR                                                |                                                 |
| MALE                                                                                                                                                                                                                                                                                                                                                          | CAU.                                                                                                      | June 23, 1915                                                                                                                                               |  | 67 YRS.                                                                                                                                    |  | MONTHS DAYS HOURS MIN.                                         |                                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN)                                                                                                                                                                                                                                                                                                                             | 7b. CITIZEN OF WHAT COUNTRY?                                                                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                       |  |                                                                |                                                 |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                      | U.S.A.                                                                                                    |                                                                                                                                                             |  | BALTIMORE CITY MD.                                                                                                                         |  |                                                                |                                                 |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |                                                 |
| BALTIMORE                                                                                                                                                                                                                                                                                                                                                     | JOHNS HOPKINS HOSPITAL                                                                                    |                                                                                                                                                             |  | Attorney-Judge                                                                                                                             |  | Court of Special Appeals                                       |                                                 |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                  |                                                                                                           | 13b. INSIDE CITY LIMITS?                                                                                                                                    |  | 13c. STREET ADDRESS                                                                                                                        |  |                                                                |                                                 |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                         |  | 109 Vue De Leau St.                                                                                                                        |  |                                                                |                                                 |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                             |                                                                                                           | 15. MOTHER'S MAIDEN NAME                                                                                                                                    |  |                                                                                                                                            |  |                                                                |                                                 |
| OLLIE H. THOMPSON                                                                                                                                                                                                                                                                                                                                             |                                                                                                           | LOLA M. CHARLES                                                                                                                                             |  |                                                                                                                                            |  |                                                                |                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                          |                                                                                                           | 16b. SOCIAL SECURITY NO.                                                                                                                                    |  | 17. INFORMANT <u>wife</u> ADDRESS                                                                                                          |  |                                                                |                                                 |
| yes                                                                                                                                                                                                                                                                                                                                                           |                                                                                                           | WW 11                                                                                                                                                       |  | Mary Alice Turner, same as 13c                                                                                                             |  |                                                                |                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                     |                                                                                                           |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Hemorrhage</u>                                                                                                                                                                                                                                                                                                                         |                                                                                                           |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                | 3 min                                           |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Rupture Ennominate artery</u>                                                                                                                                                                                                                                                                                           |                                                                                                           |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                | 5 min                                           |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pseudomonas aeruginosa Radiant</u>                                                                                                                                                                                                                                                                                      |                                                                                                           |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                | 25 days                                         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b):<br><u>SP. Abundant Pleural effusion, Carcinoma of the Lung</u>                                                                                                                                                           |                                                                                                           |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                |                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                        |                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  | 20a. AUTOPSY?                                                                                                                              |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                                 |
| 8/26/82                                                                                                                                                                                                                                                                                                                                                       |                                                                                                           | Necrotic                                                                                                                                                    |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                       |                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR                                                                                                             |  | 21c. HOW INJURY OCCURRED (CHECK NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |  |                                                                |                                                 |
|                                                                                                                                                                                                                                                                                                                                                               |                                                                                                           |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                |                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                |                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |  |                                                                |                                                 |
|                                                                                                                                                                                                                                                                                                                                                               |                                                                                                           |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                |                                                 |
| 22a. I certify that (I) [this hospital] attended the deceased from <u>August 1, 1982</u> to <u>September 4, 1982</u> , that (I) (we) lost<br>saw the deceased alive on <u>September 4, 1982</u> , and that (in my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |                                                                                                           |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                |                                                 |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                |                                                                                                           | DEGREE                                                                                                                                                      |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED                                               |                                                 |
| <u>Harold Goll</u>                                                                                                                                                                                                                                                                                                                                            |                                                                                                           | MD                                                                                                                                                          |  |                                                                                                                                            |  | 9/4/82                                                         |                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                         |                                                                                                           | 22e. ADDRESS                                                                                                                                                |  |                                                                                                                                            |  |                                                                |                                                 |
| Harold Goll                                                                                                                                                                                                                                                                                                                                                   |                                                                                                           | Johns Hopkins Hospital                                                                                                                                      |  |                                                                                                                                            |  |                                                                |                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                  |                                                                                                           | 23b. DATE                                                                                                                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                         |  | 23d. LOCATION                                                  |                                                 |
| burial                                                                                                                                                                                                                                                                                                                                                        |                                                                                                           | 9/7/82                                                                                                                                                      |  | Christ Church Cem.                                                                                                                         |  | Cambridge, Dorchester, Md                                      |                                                 |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                          |                                                                                                           |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                              |  |                                                                |                                                 |
| CURRAN FUNERAL HOME, 3085 High St.<br>Cambridge, Md                                                                                                                                                                                                                                                                                                           |                                                                                                           |                                                                                                                                                             |  | SEP 8 1982                                                                                                                                 |  |                                                                |                                                 |
|                                                                                                                                                                                                                                                                                                                                                               |                                                                                                           |                                                                                                                                                             |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                 |  |                                                                |                                                 |
|                                                                                                                                                                                                                                                                                                                                                               |                                                                                                           |                                                                                                                                                             |  | <u>John J. Carver</u>                                                                                                                      |  |                                                                |                                                 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified by item 1.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                          |  | 8 2                                                                                                                                          |  | 2 3 5 4 5                                                                                                                                                   |  | REG. NO. 371-129                                                                                |  |                                                                                                                            |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Conrad Thompson</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                              |  |                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>9/12/82</b>                                              |  | 2b. HOUR<br><b>11:00 PM</b>                                                                                                |  |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br><b>Black</b>                                                                                                                      |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>4-27-1910</b>                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS                                                |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>South Carolina</b>                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, City</b> MD.                              |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Wyman Park Health System</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                   |  | 13b. COUNTY                                                                                                                                  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3452 Auchentoroly Terr.</b>                                                                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                              |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bertha Thompson</b>                                                                                     |  |                                                                                                 |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.<br><b>218-05-1947</b>                                                                                               |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Thelma Parrott 3452 Auchentoroly Terr.</b>                                                                              |  |                                                                                                 |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure-Respiratory Acidosis</b> 1hour<br>2501<br>DUE TO, OR AS A CONSEQUENCE OF -Sepsis<br>(b) <b>Diabetic Ketoacidosis-Aspiration Pneumonia</b> 24hours<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                               |  |                                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>COPD(Bronchitis-Emphysema) Asthma</b>                                                                                                                                                                                                    |  |                                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION<br><b>N/A</b>                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>N/A</b>                                                                               |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>                                                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                 |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                       |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/11/82</b> , 19 <b>82</b> , to <b>9/12/82</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>9/12/82</b> , 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>P.T. Pham</b>                                                                                                                                                                                                                                                                                                                                              |  | DEGREE<br><b>MD</b>                                                                                                                          |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |                                                                                                 |  | 22c. DATE SIGNED<br><b>9/13/82</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>P.T. Pham, M.D.</b>                                                                                                                                                                                                                                                                                                                 |  | 22e. ADDRESS<br><b>3100 Wyman Park Drive</b>                                                                                                 |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br><b>9-19-82</b>                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Kings Memorial</b>                                                                                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto, Co Md</b>                               |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Joseph L. Russ</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                              |  | 24b. ADDRESS<br><b>222 W. North Ave</b>                                                                                                                     |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 17 1982</b>                                             |  |                                                                                                                            |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 5 4 6

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                |                                                      |                                                                                                                                                             |                           |                                                                                                                            |                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Seymour V. R. Thompson</b>                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9/6/82</b> |                                                                                                                                                             | 2b. HOUR<br><b>12:10P</b> |                                                                                                                            |                                                                               |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br><b>Black</b>                                                                                                                                        |                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 22 23</b>                                                                                                       |                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.              |                                                                               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                     |                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                          |                                                                               |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>John Hopkins Hospital</b>                      |                                                      |                                                                                                                                                             |                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                           |                                                                               |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                            |  | 13b. COUNTY                                                                                                                                                    |                                                      | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                                                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Sonny Davis</b>                                                                                                                                                                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Virginia Ricks</b>                                                                                         |                                                      | 16. SOCIAL SECURITY NO.<br><b>212-64-1800</b>                                                                                                               |                           |                                                                                                                            |                                                                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br><b>212-64-1800</b>                                                                                                                 |                                                      | 17. INFORMANT ADDRESS<br><b>Tina Bland 7220 McClean Blvd.</b>                                                                                               |                           |                                                                                                                            |                                                                               |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>hypotension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>metastatic carcinoma tumor</b><br>disc. 2 years ago                                               |  |                                                                                                                                                                |                                                      |                                                                                                                                                             |                           |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 min</b><br><b>14 hrs</b> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>                                                                                                                                                                                                                              |  |                                                                                                                                                                |                                                      |                                                                                                                                                             |                           |                                                                                                                            |                                                                               |
| 19a. DATE OF OPERATION<br><b>None</b>                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>None</b>                                                                                                |                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>                                                                                                   |                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                           |                                                                                                                            |                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                         |                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                           |                                                                                                                            |                                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 31</b> , 19 <b>82</b> , to <b>Sept 6</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>Sept 6</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                                |                                                      |                                                                                                                                                             |                           |                                                                                                                            |                                                                               |
| 22b. SIGNATURE<br><b>Richard A. Lange</b>                                                                                                                                                                                                                                                                                                                                |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                      |                                                                                                                                                             |                           | 22c. DATE SIGNED                                                                                                           |                                                                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RICHARD A. LANGE</b>                                                                                                                                                                                                                                                                                                         |  | 22e. ADDRESS<br><b>Johns Hopkins Hosp. 600 N Wolfe St, Balto</b>                                                                                               |                                                      |                                                                                                                                                             |                           |                                                                                                                            |                                                                               |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br><b>9/11/82</b>                                                                                                                                    |                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar /hill Cem</b>                                                                                                |                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                                                         |                                                                               |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/ H 1101 E. North Avenue</b>                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                |                                                      | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 8 1982</b>                                                                                                          |                           |                                                                                                                            |                                                                               |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                |                                                      |                                                                                                                                                             |                           |                                                                                                                            |                                                                               |



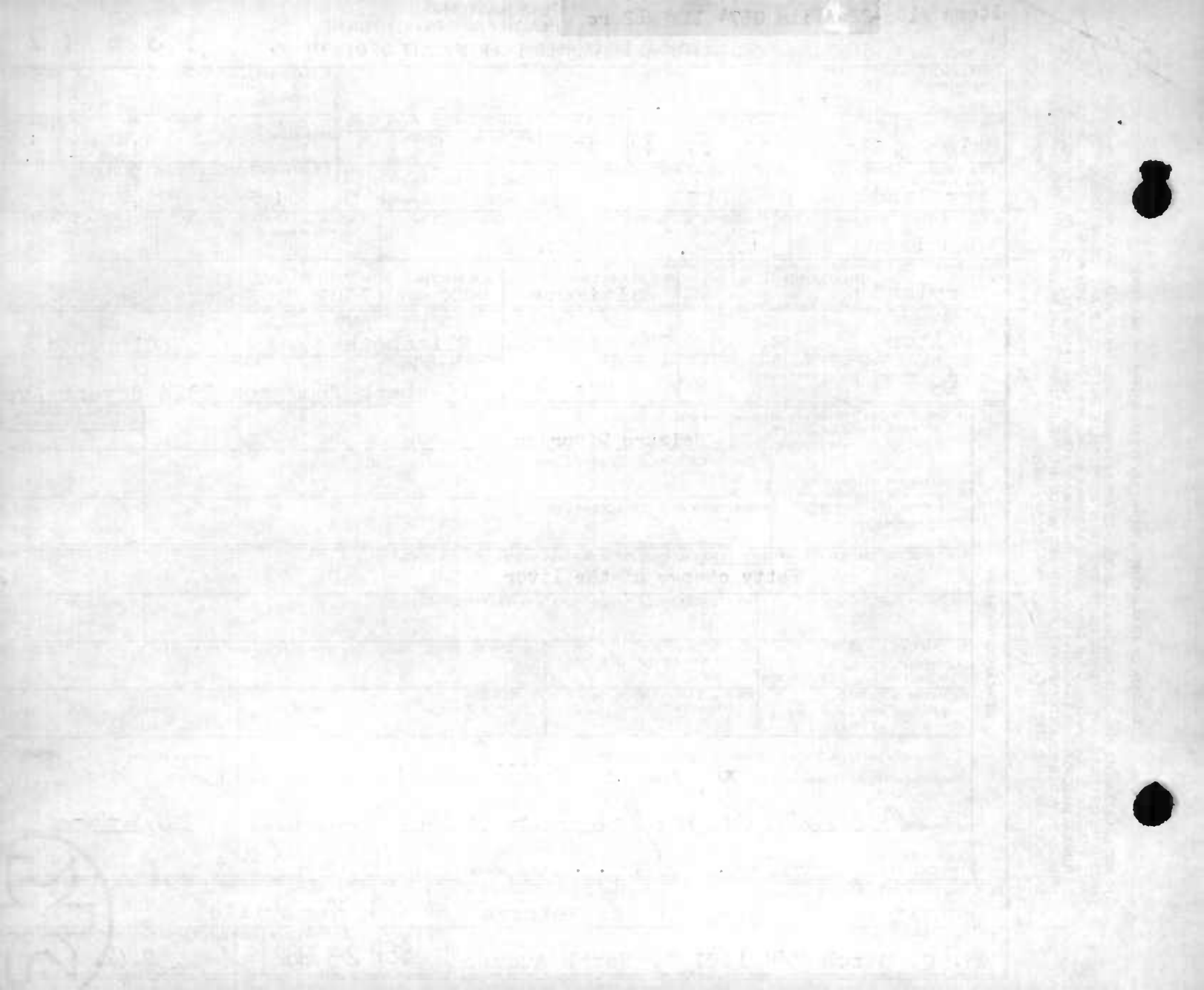
20% COTTON FIBER

Items #18a-22a Film G574 11/0/82 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

2 2 3 5 4 7 REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                      |                                                                     |                                                                                                                                                          |                                                                |                                                               |                   |                                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|---------------------------------------------------------------|-------------------|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Walter E. Thompson                                                                                                                                                                                                                                                                                                                                                                              |                  |                                                                                                                                      | 2a. DATE KNOWN OF DEATH<br>XX MONTH DAY YEAR<br>9 19 82             |                                                                                                                                                          |                                                                | 2b. HOUR<br>M<br>9:25 P. M.                                   |                   |                                   |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                         | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 27 44                                                                                       | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>37 YRS.                       | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN                                                                                                                  | IF UNDER 24 HRS.                                               | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>9 19 82         | 2d. HOUR<br>P. M. |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                  |                                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.   |                   |                                   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                 |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1502 E. Federal Street |                                                                     |                                                                                                                                                          |                                                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                   | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                 |                  | 13b. COUNTY                                                                                                                          | 13c. CITY OR TOWN<br>Baltimore                                      |                                                                                                                                                          | 13d. INSIDE CITY LIMITS?<br>YES XX NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>1502 E. Federal St.                    |                   |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Walter E. Thompson Sr.                                                                                                                                                                                                                                                                                                                                                                       |                  |                                                                                                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Clements |                                                                                                                                                          |                                                                |                                                               |                   |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                            |                  | (IF YES, GIVE WAR OR DATES)                                                                                                          |                                                                     | 16b. SOCIAL SECURITY NO.<br>N/A                                                                                                                          |                                                                | 17. INFORMANT ADDRESS<br>Elizabeth Thompson 2314 Bryant Ave   |                   |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Seizure Disorder</u><br>5718<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |                  |                                                                                                                                      |                                                                     |                                                                                                                                                          |                                                                |                                                               |                   |                                   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1<br>Fatty change of the liver                                                                                                                                                                                                                                                                            |                  |                                                                                                                                      |                                                                     |                                                                                                                                                          |                                                                |                                                               |                   |                                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                    |                                                                     |                                                                                                                                                          |                                                                | 20. AUTOPSY?<br>YES XX NO <input type="checkbox"/>            |                   |                                   |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                 |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                           |                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |                                                                |                                                               |                   |                                   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                              |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                          |                                                                     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                        |                                                                |                                                               |                   |                                   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |                                                                                                                                      |                                                                     |                                                                                                                                                          |                                                                |                                                               |                   |                                   |
| ACTUAL SIGNATURE<br>Dennis F. Smyth M.D.                                                                                                                                                                                                                                                                                                                                                                                               |                  | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER                                                                                        |                                                                     |                                                                                                                                                          |                                                                | DATE SIGNED<br>9-20-82                                        |                   |                                   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Dennis F. Smyth, M.D.                                                                                                                                                                                                                                                                                                                                                                            |                  | ADDRESS<br>111 Penn Street                                                                                                           |                                                                     |                                                                                                                                                          |                                                                |                                                               |                   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                 |                  | 23b. DATE<br>9/23/82                                                                                                                 |                                                                     | 23c. NAME OF CEMETERY OR CREMATORY<br>M d. Veteran Cem                                                                                                   |                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crownsville Md. |                   |                                   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Avenue                                                                                                                                                                                                                                                                                                                                                                  |                  |                                                                                                                                      |                                                                     | 25a. DATE REC'D. BY REGISTRAR<br>SEP 23 1982                                                                                                             |                                                                | 25b. REGISTRAR'S SIGNATURE<br>Joan J. Carver                  |                   |                                   |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 2 3 5 4 8

|                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                  |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Joseph E. Thornton                                                                                                                                                                                                                                                                                                                                                                                             |  |                  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>9 5 1982                                 |  |                                                                                                                                                             |  | 2b. HOUR<br>M<br>9:16 a. M                                                                      |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br>Black |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 9 25                                                                                        |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>51 57 58                                                                                                            |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>9 6 1982                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia                                                                                                                                                                                                                                                                                                                                                                                                 |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                 |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD                                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1711 N. Bethel Street |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                  |  | 13b. COUNTY                                                                                                                         |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Thornton                                                                                                                                                                                                                                                                                                                                                                                            |  |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Georgia Freeman                                                                    |  |                                                                                                                                                             |  |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                                                                                                          |  |                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-22-6745                                                              |  | 17. INFORMANT<br>ADDRESS<br>Lawrence Thornton 1763 Darley Ave                                                                                               |  |                                                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                           |  |                  |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                 |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).                                                                                                                                                                                                                                                                                                                   |  |                  |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                   |  |                                                                                                                                                             |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                               |  |                                                                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                        |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                                 |  |
| ACTUAL SIGNATURE<br>Dennis F. Smyth, M.D.                                                                                                                                                                                                                                                                                                                                                                                                             |  |                  |  | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER                                                                                       |  |                                                                                                                                                             |  | DATE SIGNED<br>9-6-82                                                                           |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Dennis F. Smyth, M.D.                                                                                                                                                                                                                                                                                                                                                                                           |  |                  |  | ADDRESS<br>111 Penn Street                                                                                                          |  |                                                                                                                                                             |  |                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                |  |                  |  | 23b. DATE<br>9/9/82                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Veteran Cemetery                                                                                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crownsville Md.                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/ H                                                                                                                                                                                                                                                                                                                                                                                                     |  |                  |  | ADDRESS<br>1101 E. North Avenue                                                                                                     |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 8 1982                                                                                                                 |  |                                                                                                 |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE REGISTRAR. GIVE PAGE 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM-PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WEATHERS HILLS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                     |  |                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                |  |                                                                                      |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                             |  | 8 2 2 3 5 4 9<br>REG. NO.                                                                                               |  |                                                                                                                                                             |  |                                                                                                |  |                                                                                      |  |
| 1. DECEASED NAME<br>(Last, first, middle)<br>TILLMAN, (ESTELLE) Estella                                                                                                                                                                                                                                  |  |                                                                                                                         |  |                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Sept 14, 82                                             |  | 2b. HOUR<br>6:00 P.M.                                                                |  |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                         |  | 4. RACE<br>Negro                                                                                                        |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 22 13                                                                                                               |  | 6. AGE<br>(IN YEARS LAST BIRTHDAYS)<br>69                                                      |  | 7. UNDER 1 YEAR<br>MONTHS DAYS                                                       |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)<br>N. Carolina                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                     |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                    |  |                                                                                      |  |
| 10. CITY OR TOWN OF DEATH<br>BAUO                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAL HOSP |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(IF DECEASED WAS NOT ENGAGED IN LIFE)<br>Housewife                    |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                                 |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD 13b. COUNTY 13c. CITY OR TOWN BAUO                                                                                                                                                          |  |                                                                                                                         |  |                                                                                                                                                             |  | 14. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>5051 Pembridge Rd                                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                   |  |                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                                                                               |  |                                                                                                |  |                                                                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) No                                                                                                                                                                                                                                  |  |                                                                                                                         |  | 16b. SOCIAL SECURITY NO.<br>226-22-2457                                                                                                                     |  | 17. INFORMANT<br>Charles F Tillman                                                             |  |                                                                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>1519 IMMEDIATE CAUSE (a) BOWEL OBSTRUCTION & ASPIRATION<br>DUE TO, OR AS A CONSEQUENCE OF (b) TERMINAL GASTRIC CARCINOMA & 6 mo<br>DUE TO, OR AS A CONSEQUENCE OF (c) SARCOMA : ASCUS 20yr. |  |                                                                                                                         |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1 hr                                                                                                     |  |                                                                                                |  |                                                                                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                       |  |                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                |  |                                                                                      |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                   |  |                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                                                                |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                 |  |                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                |  |                                                                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                  |  |                                                                                                                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                  |  |                                                                                      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                |  |                                                                                                                         |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                              |  |                                                                                      |  |
| 22a. I certify that (I) this hospital attended the deceased from 9/14/82 to present, and that (my, our) opinion death occurred on the date and hour and from the causes stated                                                                                                                           |  |                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                |  |                                                                                      |  |
| 22b. SIGNATURE<br>Michael L. Linn, MD                                                                                                                                                                                                                                                                    |  |                                                                                                                         |  | 22c. DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |                                                                                                |  | 22d. DATE SIGNED<br>Sept 14, 82                                                      |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MICHAEL LINN                                                                                                                                                                                                                                                    |  |                                                                                                                         |  | 22f. ADDRESS<br>10007 Falls Rd, 21093                                                                                                                       |  |                                                                                                |  |                                                                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                   |  | 23b. DATE<br>9/20/82                                                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Crypt                                                                                                         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arbutus, Md                                      |  |                                                                                      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March                                                                                                                                                                                                                                                             |  |                                                                                                                         |  | 24b. ADDRESS<br>Ft 1101 E. North Ave                                                                                                                        |  | 25. DATE REC'D BY REGISTRAR<br>SEP 17 1982                                                     |  |                                                                                      |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the health officer after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                         |  |                                                                    |  | REG. NO. 8 2 2 3 5 5 0                       |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|--|----------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>WILLIE TILLMAN</b>                                                                    |  |                                                                                                                                                             |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Sept 17 82</b>                                                                   |  | 2b. HOUR<br><b>8:15A</b>                                           |  |                                              |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE<br><b>Black</b>                                                                                                                        |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>5 15 1908</b>                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br><b>74</b>                                                                        |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.          |  |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                     |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                       |  |                                                                    |  |                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>John L. Deaton Medical Center</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY                                  |  |                                              |  |
| 13a. STATE<br><b>Md</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 13b. COUNTY<br><b>Balto</b>                                                                                                                    |  | 13c. CITY OR TOWN<br><b>Balto</b>                                                                                                                           |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS<br><b>1632 Druid Hill Ave</b>                  |  |                                              |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                                                                     |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                           |  | 16b. SOCIAL SECURITY NO.                                                                                                |  | 17. INFORMANT ADDRESS<br><b>Sadie Fleming 1632 Druid Hill Ave.</b> |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 16b. SOCIAL SECURITY NO.                                                                                                                       |  | 17. INFORMANT ADDRESS<br><b>Sadie Fleming 1632 Druid Hill Ave.</b>                                                                                          |  |                                                                                                                         |  |                                                                    |  |                                              |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PULMONARY ARREST</b><br><b>4960</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>COPD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>chronic brain syndrome, hypertension, alcohol disease</b> |  |                                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                         |  |                                                                    |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                               |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                                    |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER).                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)                                                                              |  |                                                                                                                         |  |                                                                    |  |                                              |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                            |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                         |  |                                                                    |  |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 6</b> , 19 <b>82</b> , to <b>Sept. 17</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>Sept 16</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                                 |  |                                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                         |  |                                                                    |  | 22c. DATE SIGNED<br><b>9-17-82</b>           |  |
| 22b. SIGNATURE<br><b>a.D. Carter MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | DEGREE                                                                                                                                         |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |                                                                                                                         |  |                                                                    |  |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ANN D. CARTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 22e. ADDRESS<br><b>J. L. Deaton Medical Center</b>                                                                                             |  |                                                                                                                                                             |  |                                                                                                                         |  |                                                                    |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 23b. DATE<br><b>9-21-82</b>                                                                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Zion Cem</b>                                                                                                    |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Md</b>                                                          |  |                                                                    |  |                                              |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Brown/Thompson F. H.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 23 1982</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carter</b>                                                                     |  |                                                                    |  |                                              |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                   |                                            |                                                                                                                                        |                                                                                                                                                             |                                                                                | REG. NO. 8 2 2 3 5 5 1                                                    |                                                                                                 |                                                                                                                            |                                                |                          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|--------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELIZABETH TILLMOND</b>                                                                                                                                                                                                                                                                                                          |                                            |                                                                                                                                        |                                                                                                                                                             |                                                                                | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 8 82</b>                      |                                                                                                 |                                                                                                                            |                                                | 2b. HOUR<br><b>9 18p</b> |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                | 4. RACE<br><b>Black</b>                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 6 15</b>                                                                                    |                                                                                                                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.                              |                                                                           | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                       |                                                                                                                            | IF UNDER 24 HRS.                               |                          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                           | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |                                                                                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD</b>          |                                                                                                 |                                                                                                                            |                                                |                          |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                          |                                            | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b> |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                |                          |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                               |                                            | 13b. COUNTY<br><b>Baltimore</b>                                                                                                        |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Baltimore</b>                                          |                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS<br><b>1632 Bentalow St</b> |                          |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Prosser Tillmond</b>                                                                                                                                                                                                                                                                                                      |                                            |                                                                                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Grimes</b>                                                                                        |                                                                                |                                                                           |                                                                                                 |                                                                                                                            |                                                |                          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                      |                                            | 16b. SOCIAL SECURITY NO.<br><b>675-22-7487</b>                                                                                         |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>Rosa Griffith 3303 Woodland Ave</b>             |                                                                           |                                                                                                 |                                                                                                                            |                                                |                          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br><b>1830</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Bronchopneumonia</b><br>(c) <b>Malignant Ascites CA ovary</b>               |                                            |                                                                                                                                        |                                                                                                                                                             |                                                                                |                                                                           |                                                                                                 |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                   |                                            |                                                                                                                                        |                                                                                                                                                             |                                                                                |                                                                           |                                                                                                 |                                                                                                                            |                                                |                          |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                 |                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |                                                                                                                                                             |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                |                          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                               |                                            | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                      |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                           |                                                                                                 |                                                                                                                            |                                                |                          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                         |                                            | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.)                                                                      |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                           |                                                                                                 |                                                                                                                            |                                                |                          |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/26</b> , 19 <b>82</b> , to <b>9-8</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>9-8</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |                                            |                                                                                                                                        |                                                                                                                                                             |                                                                                |                                                                           |                                                                                                 |                                                                                                                            |                                                |                          |
| 22b. SIGNATURE<br><b>Sher Afzal Hashmi MD</b>                                                                                                                                                                                                                                                                                                                          |                                            |                                                                                                                                        |                                                                                                                                                             |                                                                                | DEGREE<br><b>MD</b>                                                       |                                                                                                 | 22c. DATE SIGNED                                                                                                           |                                                |                          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SHER AFZAL HASHMI</b>                                                                                                                                                                                                                                                                                                      |                                            |                                                                                                                                        |                                                                                                                                                             |                                                                                | 22e. ADDRESS<br><b>PROVIDENT HOSPITAL 21216</b>                           |                                                                                                 |                                                                                                                            |                                                |                          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                          |                                            | 23b. DATE<br><b>9/13/82</b>                                                                                                            |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Auburn Cem</b>                     |                                                                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto Md</b>                                   |                                                                                                                            |                                                |                          |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C. March F/H 1012 North</b>                                                                                                                                                                                                                                                                                              |                                            |                                                                                                                                        |                                                                                                                                                             |                                                                                | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 10 1982</b>                       |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canine</b>                                                                        |                                                |                          |



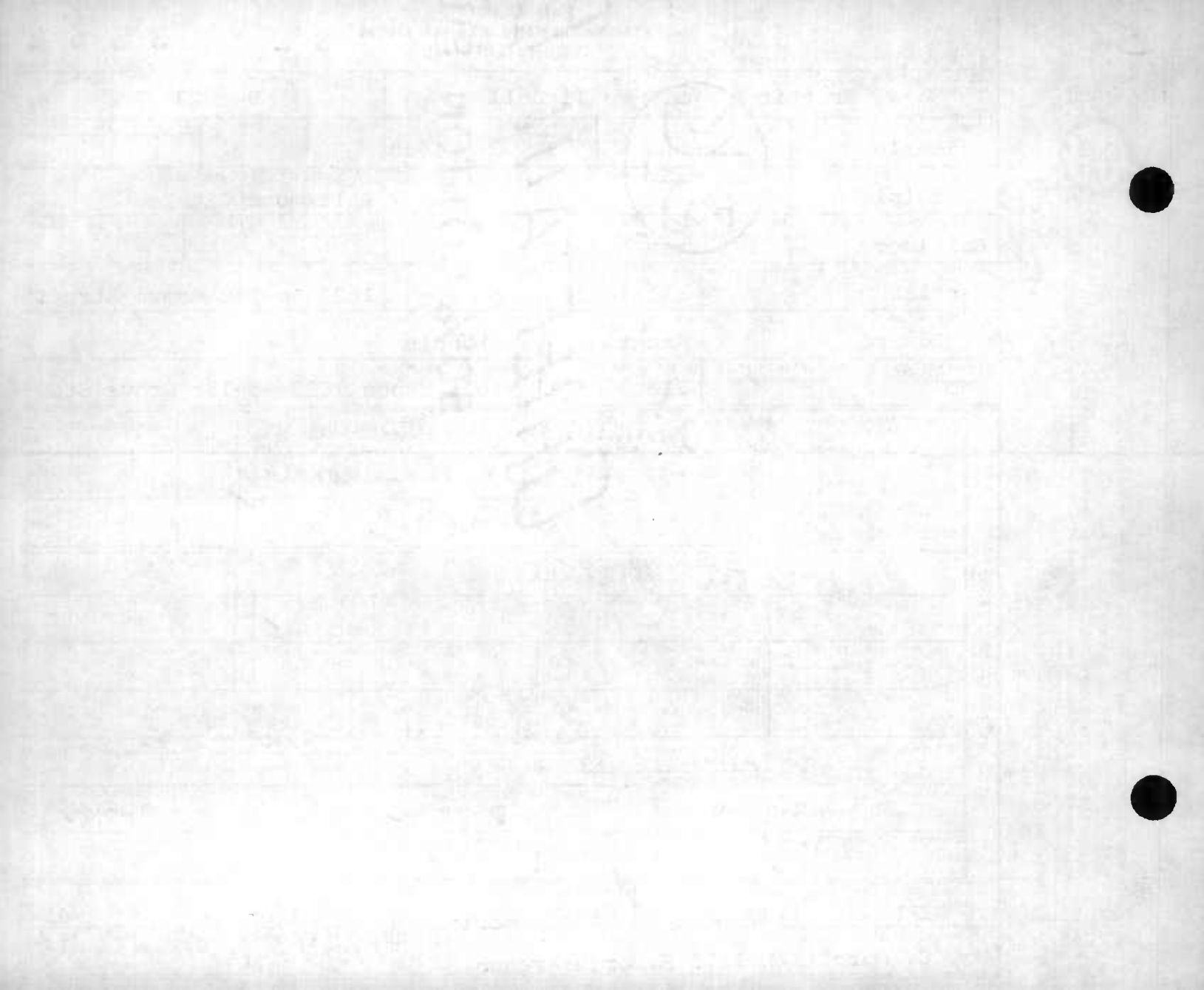


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                    |  | REG. NO. 8 2 2 3 5 5 2                                                                                                                                   |  |                                                                                                                         |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                    |  |                                                                                                                                                          |  |                                                                                                                         |                                              |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Brittie A. Tindull</b>                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                    |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>9 23 82</b>                                                                                                       |  | 2b. HOUR<br><b>M</b>                                                                                                    |                                              |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br><b>Black</b>                                                                                                            |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>3 3 1900</b>                                                                                                       |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>82 YRS</b>                                                 |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US_A</b>                                                                                        |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.                                                      |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |                                              |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY                                                                                                                        |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                    |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Edward Arnett</b>                                                                                                                                                                                                                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Nannie</b>                                                                        |  | 13e. STREET ADDRESS<br><b>1623 Poplar Grove Street</b>                                                                                                   |  |                                                                                                                         |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.<br><b>213-30-6711</b>                                                                                     |  | 17. INFORMANT ADDRESS<br><b>Viola Mason 1623 Poplar Grove St,</b>                                                                                        |  |                                                                                                                         |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Heart Failure</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>acute coronary</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>OSCD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                    |  |                                                                                                                                                          |  |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Diabetes Mellitus</b>                                                                                                                                                                                                                          |  |                                                                                                                                    |  |                                                                                                                                                          |  |                                                                                                                         |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                           |  |                                                                                                                         |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>Market</b>                                               |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>81 3/10 8v</b>                                                                                      |  |                                                                                                                         |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/10</b> , 19 <b>8v</b> , to <b>3/10</b> , 19 <b>8v</b> , that (I) (we) last saw the deceased alive on <b>8/10</b> , 19 <b>8v</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.                          |  |                                                                                                                                    |  |                                                                                                                                                          |  |                                                                                                                         |                                              |
| 22b. SIGNATURE<br><b>Ngayoso</b>                                                                                                                                                                                                                                                                                                                                                          |  | DEGREE<br><b>M.D.</b>                                                                                                              |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED<br><b>9/23/82</b>                                                                                      |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                     |  | 22e. ADDRESS                                                                                                                       |  |                                                                                                                                                          |  |                                                                                                                         |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br><b>9/ 25/82</b>                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Pk</b>                                                                                            |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                                                         |                                              |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm. C. March F/H 1101 E. North Avenue</b>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                    |  | 25a. TIME RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>SEP 24 1982 John J. Linn</b>                                                            |  |                                                                                                                         |                                              |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                  |                         |                                                                                                                                       |                                                                        |                                    |                                                                                                                                                           |                                                                                                 |                                                                                                                                            |                                                                   |                                                                                                                            |                                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                       |                                                                        |                                    |                                                                                                                                                           |                                                                                                 |                                                                                                                                            |                                                                   |                                                                                                                            |                                                |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SELENA TITTLE</b>                                                                                                                                                                                                                                                                              |                         |                                                                                                                                       |                                                                        |                                    | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>9/9/82</b>                                                                                                         |                                                                                                 |                                                                                                                                            |                                                                   |                                                                                                                            | 2b. HOUR<br><b>4:45</b> M                      |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                               | 4. RACE<br><b>Negro</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>5/24/19</b>                                                                                     |                                                                        |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.                                                                                                         |                                                                                                 |                                                                                                                                            | 7. UNDER 1 YEAR<br>MONTHS DAYS                                    |                                                                                                                            | 8. UNDER 74 HRS<br>HOURS MIN.                  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Sumter, SC</b>                                                                                                                                                                                                                                                                        |                         | 9b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                         |                                                                        |                                    | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                                 |                                                                                                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |                                                                                                                            |                                                |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore MD.</b>                                                                                                                                                                                                                                                                                     |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LUTHERAN Hospital</b> |                                                                        |                                    |                                                                                                                                                           |                                                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                           |                                                                   | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                               |                         | 13b. COUNTY                                                                                                                           |                                                                        | 13c. CITY OR TOWN<br><b>Balto.</b> |                                                                                                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                            | 13e. STREET ADDRESS<br><b>2521 W. Forest Park Ave.</b>            |                                                                                                                            |                                                |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Keene</b>                                                                                                                                                                                                                                                                           |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bertha Wright</b>                                                                 |                                                                        |                                    | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>                                                                            |                                                                                                 |                                                                                                                                            |                                                                   |                                                                                                                            | 16b. SOCIAL SECURITY NO.<br><b>215-12-5638</b> |
| 17. INFORMANT<br><b>Mae E. Bate</b>                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                       |                                                                        |                                    | ADDRESS<br><b>2521 W. Forest Pk. Ave.</b>                                                                                                                 |                                                                                                 |                                                                                                                                            |                                                                   |                                                                                                                            |                                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>3109</b> IMMEDIATE CAUSE (a) <b>Decubitus ulcer</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CVA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>C O I B S</b> |                         |                                                                                                                                       |                                                                        |                                    |                                                                                                                                                           |                                                                                                 |                                                                                                                                            |                                                                   |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)                                                                                                                                                                                                  |                         |                                                                                                                                       |                                                                        |                                    |                                                                                                                                                           |                                                                                                 |                                                                                                                                            |                                                                   |                                                                                                                            |                                                |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                    |                                                                                                                                                           |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |                                                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                  |                         |                                                                                                                                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                            |                                                                                                 |                                                                                                                                            |                                                                   |                                                                                                                            |                                                |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                          |                         |                                                                                                                                       | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                         |                                                                                                 |                                                                                                                                            |                                                                   |                                                                                                                            |                                                |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/14/82</b> to <b>9/9/82</b> , that (I) (we) last saw the deceased alive on <b>9/9/82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                    |                         |                                                                                                                                       |                                                                        |                                    |                                                                                                                                                           |                                                                                                 |                                                                                                                                            |                                                                   |                                                                                                                            |                                                |
| 22b. SIGNATURE<br><b>Dr. M. E. Brennan</b>                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                       |                                                                        |                                    | DEGREE<br><b>MD</b>                                                                                                                                       |                                                                                                 | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                   | 22c. DATE SIGNED<br><b>9/9/82</b>                                                                                          |                                                |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. E. Brennan</b>                                                                                                                                                                                                                                                                         |                         |                                                                                                                                       |                                                                        |                                    | 22e. ADDRESS                                                                                                                                              |                                                                                                 |                                                                                                                                            |                                                                   |                                                                                                                            |                                                |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                            |                         |                                                                                                                                       | 23b. DATE<br><b>9/13/82</b>                                            |                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>                                                                                             |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus MD</b>                                                                            |                                                                   |                                                                                                                            |                                                |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March f/h, Inc.</b>                                                                                                                                                                                                                                                                         |                         |                                                                                                                                       |                                                                        |                                    | ADDRESS<br><b>1101 E. North</b>                                                                                                                           |                                                                                                 | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 15 1982</b>                                                                                        |                                                                   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                                                        |                                                |

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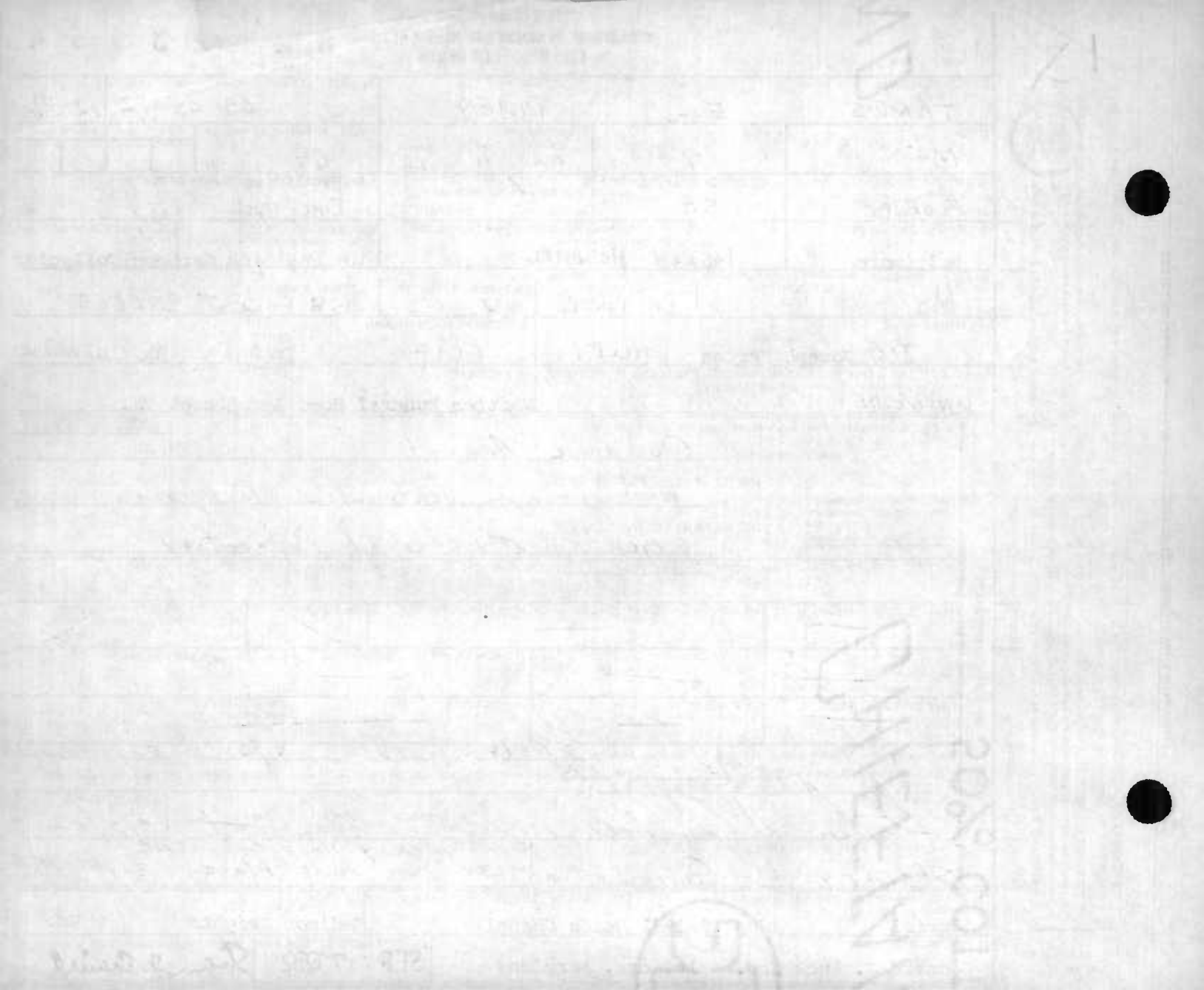
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                           |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                      |  |                                                                                              |                                   | REG. NO. 8 2 2 3 5 5 4                                                                                                             |  |  |  |                             |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|-----------------------------------|------------------------------------------------------------------------------------------------------------------------------------|--|--|--|-----------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                      |  |                                                                                              |                                   |                                                                                                                                    |  |  |  |                             |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>JAMES E. TOLLEY</b>                                                                                                                                                                                                                                                                                   |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                      |  |                                                                                              |                                   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>09 05 82</b>                                                                                |  |  |  | 2b. HOUR<br><b>12:39 PM</b> |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br><b>White</b>                                                                                                         |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>02 11 18</b>                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br><b>64</b>                                                     |  | IF UNDER 1 YEAR MONTHS DAYS<br><b>0 0</b>                                                    |                                   | IF UNDER 24 HRS. HOURS MIN.<br><b>0 0</b>                                                                                          |  |  |  |                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>FLORIDA</b>                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                      |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE, CITY</b> MD.                                   |  |                                                                                              |                                   |                                                                                                                                    |  |  |  |                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERCY HOSPITAL</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Unemployed Garbage Collector</b> |  |                                                                                              | 12b. KIND OF BUSINESS OR INDUSTRY |                                                                                                                                    |  |  |  |                             |  |
| 13a. STATE<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                 |  | 13b. COUNTY                                                                                                                                                 |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET ADDRESS<br><b>954 FOREST STREET</b>                                                                                    |  |  |  |                             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>JOE Joseph Harten TOLLEY</b>                                                                                                                                                                                                                                                                                         |  |                                                                                                                                 |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>EULA EDNA MCCORMICK</b>                                                                                    |  |                                                                                                      |  |                                                                                              |                                   |                                                                                                                                    |  |  |  |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                |  |                                                                                                                                 |  | 16b. SOCIAL SECURITY NO.<br><b>-</b>                                                                                                                        |  | 17. INFORMANT ADDRESS<br><b>Whitten Funeral Home Lynchburg, Va.</b>                                  |  |                                                                                              |                                   |                                                                                                                                    |  |  |  |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Refractory Ventricular Tachycardia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute Myocardial Infarction</b>                                    |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                      |  |                                                                                              |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                       |  |  |  |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>                                                                                                                                                                                                                      |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                      |  |                                                                                              |                                   |                                                                                                                                    |  |  |  |                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                                                                      |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                             |  |                                                                                                                                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                       |  |                                                                                              |                                   |                                                                                                                                    |  |  |  |                             |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                       |  |                                                                                                                                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                         |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                       |  |                                                                                              |                                   |                                                                                                                                    |  |  |  |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/8/82</b> , 19 <b>82</b> , to <b>9/5</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>9/5</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) view the body after death. |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                      |  |                                                                                              |                                   |                                                                                                                                    |  |  |  |                             |  |
| 22b. SIGNATURE DEGREE<br><b>Stephen D. Campbell, MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                                                                                                                                                             |  |                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                      |  |                                                                                              |                                   | 22c. DATE SIGNED<br><b>9/5/82</b>                                                                                                  |  |  |  |                             |  |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Stephen D. Campbell, MD</b>                                                                                                                                                                                                                                                                                        |  |                                                                                                                                 |  |                                                                                                                                                             |  | 23b. ADDRESS<br><b>Mercy Hospital, Inc. 301 St. Paul Place Balto, Md.</b>                            |  |                                                                                              |                                   |                                                                                                                                    |  |  |  |                             |  |
| 23c. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                 |  | 23d. DATE<br><b>Sept. 9, 1982</b>                                                                                                                           |  | 23e. NAME OF CEMETERY OR CREMATORY<br><b>Meads Chapel</b>                                            |  | 23f. LOCATION CITY OR TOWN COUNTY STATE<br><b>Madison Heights Va.</b>                        |                                   |                                                                                                                                    |  |  |  |                             |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                   |  |                                                                                                                                 |  |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 7 1982</b>                                                   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connelley</b>                                       |                                   |                                                                                                                                    |  |  |  |                             |  |





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 5 5 5

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                     |                                                                                    |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |                                                                                                                                                                |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JEARY W. TOOMER</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                     | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>SEPT 20, 1982</b>                           |                                                                                                                                                             |  | 2b. HOUR<br><b>M</b>                                                                            |  |                                                                                                                            |                                                                                                                                                                |  |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><b>BLACK</b>                                                                                                             |                                                                                    | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>AUG 18, 1911</b>                                                                                                      |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.                                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                                                                                   |                                                                                                                                                                |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>                                                                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                                                                                        |                                                                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |                                                                                                                            |                                                                                                                                                                |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IS NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1800 RUXTON AVE</b> |                                                                                    |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                                                                                                                                                |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE <b>MARYLAND</b> 13b COUNTY <b>BALTIMORE</b> 13c CITY OR TOWN <b>BALTIMORE</b>                                                                                                                                                                                                                                   |  |                                                                                                                                     |                                                                                    |                                                                                                                                                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1800 RUXTON AVE</b>                                                                              |                                                                                                                                                                |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>JACOB TOOMER</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                     |                                                                                    |                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>EMALINE TOOMER</b>                             |  |                                                                                                                            |                                                                                                                                                                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                     | 16b. SOCIAL SECURITY NO.<br><b>W.W.H 068 010626</b>                                |                                                                                                                                                             |  | 17. INFORMANT ADDRESS<br><b>MRS MARIE TOOMER 1800 RUXTON AVE</b>                                |  |                                                                                                                            |                                                                                                                                                                |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4100 Hypertensive Cardiovascular Disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 YRS.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerosis, marked</b> <b>5 YRS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Acute Myocardial Infarction</b> <b>HOURS</b> |  |                                                                                                                                     |                                                                                    |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Arthritis, Poly</b> |  |  |
| 19a. DATE OF OPERATION<br><b>—</b>                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>                       |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                                                |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                  |  |                                                                                                                                     | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>— — — 19</b>                    |                                                                                                                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>—</b>      |  |                                                                                                                            |                                                                                                                                                                |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>—</b> |                                                                                                                                                             |  | 21f. LOCATION<br>STREET <b>—</b> CITY OR TOWN <b>—</b> COUNTY <b>—</b> STATE <b>—</b>           |  |                                                                                                                            |                                                                                                                                                                |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March</b> , 19 <b>62</b> , to <b>Sept</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>AUG 2</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                |  |                                                                                                                                     |                                                                                    |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |                                                                                                                                                                |  |  |
| 22b. SIGNATURE<br><b>James D. Solomon,</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                     |                                                                                    |                                                                                                                                                             |  | DEGREE<br><b>M.D.</b>                                                                           |  |                                                                                                                            | 22c. DATE SIGNED<br><b>9-20-82</b>                                                                                                                             |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES D. SOLOMON, M.D.</b>                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                     |                                                                                    |                                                                                                                                                             |  | 22e. ADDRESS<br><b>1919 RUXTON AVE., Balt, Md 21216</b>                                         |  |                                                                                                                            |                                                                                                                                                                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                     | 23b. DATE<br><b>9-24-82</b>                                                        |                                                                                                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Clarksville Vet Cem.</b>                               |  |                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN <b>Clarksville</b> COUNTY <b>Ind.</b> STATE <b>Ind.</b>                                                                          |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>JOSEPH L. RUSE</b> ADDRESS<br><b>2222 W. NORTH AVE</b>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                     |                                                                                    |                                                                                                                                                             |  | 25. DATE REC'D. BY REGISTRAR<br><b>SEP 22 1982</b>                                              |  |                                                                                                                            | REGISTRAR'S SIGNATURE<br><b>John J. [Signature]</b>                                                                                                            |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



6.2.05-23.8

typographic Cursive Book 2012

THE UNIVERSITY OF CHICAGO

1959, 217, 218, 219

P. J. H. ...

James D. Solomon, M.D. 1919 Ruxton Ave. Baltimore, Md. 21204

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and a post-mortem examination must be performed.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                           |  | 8 2 2 3 5 5 6<br>REG. NO.                                                                                                                                   |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Robert Town s</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                           |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 10 82</b>                                                                                                       |  |                                                                                                                            |  |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br><b>Black</b>                                                                                                                   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 23 39</b>                                                                                                       |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>42</b> YRS.                                                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Usa</b>                                                                                                |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.                                                         |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1826 N. Castle Street</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 13b. COUNTY                                                                                                                               |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br><b>1826 N. Castle St.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Petties Towns</b>                                                                            |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Carrie Chichester</b>                                                                                   |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br><b>212-36-2195</b>                                                                                            |  | 17. INFORMANT<br>ADDRESS<br><b>Geneveivie Towns 1826 Castle St.</b>                                                                                         |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral edema</b><br><b>1629</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>brain metastasis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>squamous lung carcinoma</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 weeks</b><br><b>3 months</b><br><b>12 months</b> |  |                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                          |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>June 15, 19 81</b> to <b>Sept 9, 19 82</b> , that (I) (we) last saw the deceased alive on <b>Aug 15, 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                                                                                                                                                                             |  |                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Moody D. Wharam, Jr.</b> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                           |  | 22c. DATE SIGNED<br><b>9/10/82</b>                                                                                                                          |  |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>moody D. Wharam</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                           |  | 22e. ADDRESS<br><b>Johns Hopkins</b>                                                                                                                        |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK ONE)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><b>8/15/82</b>                                                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Mem Pk.</b>                                                                                                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                                                         |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                           |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 15 1982</b>                                                                                                         |  |                                                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                           |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>                                                                                                         |  |                                                                                                                            |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                               |  |                                                                                                                            |                                                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>AUGUSTINE J. TRAGESER</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 7 82</b>                   |                                                                                                                                                             |                                                                                | 2b. HOUR<br><b>1:45 P.M.</b>                                                                                                                  |  |                                                                                                                            |                                                                 |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br><b>WHITE</b>                                                                                                                     |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 7 1908</b>                                                                                                      |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.                                                                                             |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |                                                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                               |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                                             |  |                                                                                                                            |                                                                 |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GOOD SAMARITAN HOSPITAL</b> |                                                                        |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Stationary Eng.</b>                                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>School Bd.</b>                                                                     |                                                                 |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                       |  | 13b. COUNTY<br><b>-</b>                                                                                                                     |                                                                        | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                                                                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                               |  | 13e. STREET ADDRESS<br><b>3843 Lyndale Ave. 21213</b>                                                                      |                                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>FRANCIS TRAGESER</b>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                             |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY JANZ DORSEY</b>                                                                                    |                                                                                |                                                                                                                                               |  |                                                                                                                            |                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>                                                                                                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO.<br><b>218-10-3070</b>                                                                                              |                                                                        | 17. INFORMANT<br>ADDRESS<br><b>Mary Trageser (wife) same address</b>                                                                                        |                                                                                |                                                                                                                                               |  |                                                                                                                            |                                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of lungs</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>with metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                               |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 month</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a<br><b></b>                                                                                                                                                                                                                                                   |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                               |  |                                                                                                                            |                                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                       |  |                                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                                               |  |                                                                                                                            |                                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                   |  |                                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                                               |  |                                                                                                                            |                                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>November 19 81</b> , to <b>8/7 19 82</b> , that (I) (we) lost<br>saw the deceased alive on <b>Aug 7 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                              |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                |                                                                                                                                               |  |                                                                                                                            |                                                                 |
| 22b. SIGNATURE<br><b>Felix K. Tan, M.D.</b>                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                             | DEGREE                                                                 |                                                                                                                                                             |                                                                                | ATTENDING MEDICAL STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>9/7/82</b>                                                                                          |                                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>FELIX K. TAN, M.D.</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                             | 22e. ADDRESS<br><b>3800 ZERDMAN AVE, Baltimore, Md 21213</b>           |                                                                                                                                                             |                                                                                |                                                                                                                                               |  |                                                                                                                            |                                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br><b>9/10/82</b>                                                                                                                 |                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem. Pk.</b>                                                                                              |                                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                                                                               |  |                                                                                                                            |                                                                 |
| 24. FUNERAL DIRECTOR<br><b>Schimunek Funeral Home, Inc.</b><br><b>3331 Brehms Lane, Balto. Md. 21213</b>                                                                                                                                                                                                                                                                                       |  |                                                                                                                                             |                                                                        | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 10 1982</b>                                                                                                         |                                                                                | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canine</b>                                                                                           |  |                                                                                                                            |                                                                 |

• 2000 •

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 5 5 8

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                       |                                               |                                                                                                                                                             |  |                                                                                    |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Cleon</b> <b>Tribble</b>                                                                                                                                                                                                                                                                                                                       |                                               | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>9-6-82</b>                                                                                                           |  | 2b. HOUR<br><b>6:25 P.M.</b>                                                       |  |
| 3. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE<br><b>Col.</b>                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12-21-22</b>                                                                                                       |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b>                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Indiana</b>                                                                                                                                                                                                                                                                                                                           | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                         |                                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hosp.</b>                          |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                         |                                               | 13b. COUNTY<br><b>BALTO.</b>                                                                                                                                |  | 13c. CITY OR TOWN<br><b>BALTO.</b>                                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Dennis</b> <b>Tribble</b>                                                                                                                                                                                                                                                                                                                |                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Glamie</b> <b>Alexander</b>                                                                             |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>yes</b>    |  |
| 16b. SOCIAL SECURITY NO.<br><b>Navy</b>                                                                                                                                                                                                                                                                                                                                               |                                               | 17. INFORMANT<br><b>Mrs. Ellen Tribble</b>                                                                                                                  |  | 17b. ADDRESS<br><b>3301 Oakfield Ave</b>                                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>5150</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>diffuse pulmonary interstitial fibrosis 4 yrs</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                               |                                                                                                                                                             |  |                                                                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                                                                                  |                                               |                                                                                                                                                             |  |                                                                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                |                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                              |                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)     |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                             |                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                           |                                               |                                                                                                                                                             |  |                                                                                    |  |
| 22b. SIGNATURE<br><b>Howard Jacobs</b>                                                                                                                                                                                                                                                                                                                                                |                                               | DEGREE<br><b>MD</b>                                                                                                                                         |  | 22c. DATE SIGNED<br><b>9/19/82</b>                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HOWARD JACOBS</b>                                                                                                                                                                                                                                                                                                                         |                                               | 22e. ADDRESS<br><b>3900 COCH RAVEN BLVD 21218</b>                                                                                                           |  |                                                                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                            |                                               | 23b. DATE<br><b>9-14-82</b>                                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crownsville Veteran Cem</b>               |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville Md</b>                                                                                                                                                                                                                                                                                                                   |                                               | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Joseph L. Russ 2522 W. North Ave.</b>                                                                            |  |                                                                                    |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 17 1982</b>                                                                                                                                                                                                                                                                                                                                   |                                               | REGISTRAR'S SIGNATURE<br><b>John J. Canine</b>                                                                                                              |  |                                                                                    |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                        |                                                                     |                                                                                                                                                              | 8 2 2 3 5 5 9<br>REG. NO.                                                                  |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                              |                     |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|---------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Margaret Evelyn Tribull                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                        |                                                                     |                                                                                                                                                              | 2a. DATE OF DEATH MONTH DAY YEAR<br>September 19, 1982                                     |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                              | 2b. HOUR<br>8:55P M |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br>White                                                                                                                       |                                                                     | 5. DATE OF BIRTH MONTH DAY YEAR<br>7 12 10                                                                                                                   |                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.                                                                                                 |                                                                                                 |                                                                                                                            | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN. |                     |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 9. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                  |                                                                     | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                                 |                                                                                                 |                                                                                                                            |                                                              |                     |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |                                                                     |                                                                                                                                                              |                                                                                            | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired                                                                   |                                                                                                 |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br>Housework               |                     |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                        | 13b. COUNTY<br>-----                                                |                                                                                                                                                              | 13c. CITY OR TOWN<br>Baltimore                                                             |                                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS<br>607 S. Belnord Avenue 21224           |                     |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>James Westkamp                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                        | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Margaret Duvall       |                                                                                                                                                              |                                                                                            |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                              |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                        | 16b. SOCIAL SECURITY NO.<br>214-01-4372                             |                                                                                                                                                              | 17. INFORMANT ADDRESS<br>Gordon L. Westkamp 1100 Dulaney Gate Circle Cockeville, Md. 21030 |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                              |                     |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 3940 <del>XXXXXXXXXXXXXXXXXXXX</del><br>xx Congestive Heart Failure with Mitral Stenosis, and with Mitral Regurgitation with Chronic Renal Failure.<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                        |  |                                                                                                                                        |                                                                     |                                                                                                                                                              |                                                                                            |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                              |                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                        |                                                                     |                                                                                                                                                              |                                                                                            |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                              |                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                                                                                                                                              |                                                                                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                              |                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                        | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                              |                                                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                              |                                                                                                 |                                                                                                                            |                                                              |                     |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                              |                                                                                            | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                             |                                                                                                 |                                                                                                                            |                                                              |                     |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 2, 1982, to September 19, 1982, that <input checked="" type="checkbox"/> (we) lost the deceased alive on September 19, 1982, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death. |  |                                                                                                                                        |                                                                     |                                                                                                                                                              |                                                                                            |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                              |                     |  |
| 22b. SIGNATURE<br>Parminderjeet Sandhu                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                        | DEGREE                                                              |                                                                                                                                                              |                                                                                            | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                 |                                                                                                                            | 22c. DATE SIGNED<br>9/19/82                                  |                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Parminderjeet Sandhu, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                        | 22e. ADDRESS<br>c/o Maryland General Hospital                       |                                                                                                                                                              |                                                                                            |                                                                                                                                            |                                                                                                 |                                                                                                                            |                                                              |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                        | 23b. DATE<br>9-22-82                                                |                                                                                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer Cem.                                   |                                                                                                                                            |                                                                                                 | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore City Md.                                                              |                                                              |                     |  |
| 24. FUNERAL DIRECTOR NAME<br>C.S. Zeiler & Son Inc.                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                        | ADDRESS<br>901 S. Conkling Street                                   |                                                                                                                                                              |                                                                                            | 25a. DATE REC'D. BY REGISTRAR<br>SEP 22 1982                                                                                               |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br>John J. Canish                                                                               |                                                              |                     |  |

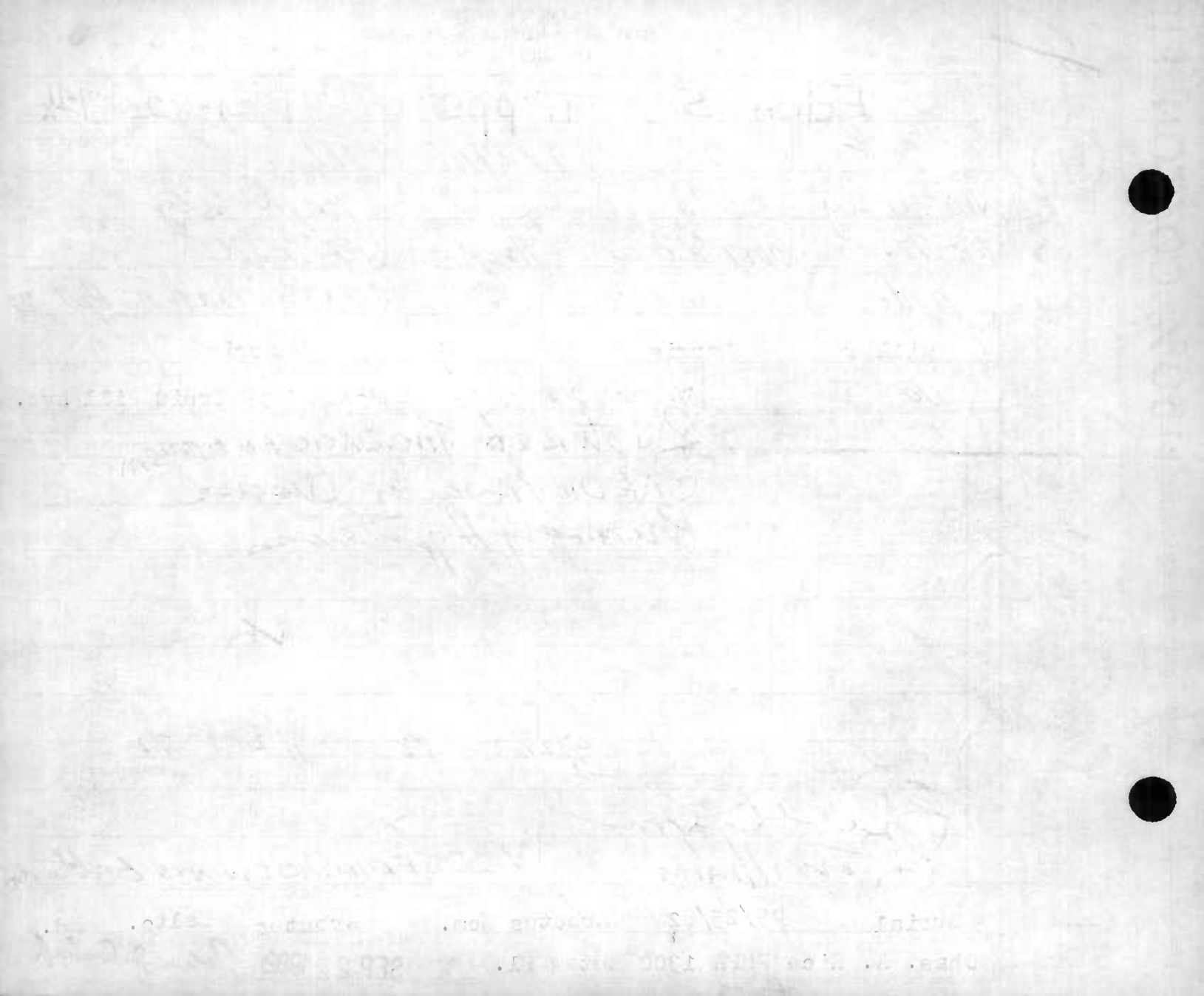


FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 5 6 0

REG. NO.

|                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                   |                                                                                                                                                             |                                                                        |  |                                                                                |                                                                                                                                                      |                                                                                                 |                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Edna S. Tripps                                                                                                                                                                                                                                                                                          |                                                                                                                                   |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9-21-82                         |  |                                                                                | 2b. HOUR<br>7:41 AM                                                                                                                                  |                                                                                                 |                                                                                                                            |
| 3. SEX<br>F                                                                                                                                                                                                                                                                                                                                   | 4. RACE<br>B                                                                                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9/11/11                                                                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS                              |  |                                                                                | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                                            |                                                                                                 |                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New Jersey                                                                                                                                                                                                                                                                                       | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.                  |  |                                                                                |                                                                                                                                                      |                                                                                                 |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Barnes & Noble Hosp. |                                                                                                                                                             |                                                                        |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired    |                                                                                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |                                                                                                                            |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD.                                                                                                                                                                                                                             |                                                                                                                                   |                                                                                                                                                             | 13b. COUNTY<br>Baltimore                                               |  | 13c. CITY OR TOWN<br>Baltimore                                                 |                                                                                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            |
| 14. FATHER'S NAME<br>William Harris                                                                                                                                                                                                                                                                                                           |                                                                                                                                   |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>Helen Harris                               |  |                                                                                |                                                                                                                                                      |                                                                                                 |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                    |                                                                                                                                   |                                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br>26-28-8316                                 |  | 17. INFORMANT<br>Marlyn Randolph                                               |                                                                                                                                                      |                                                                                                 |                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                   |                                                                                                                                                             | ADDRESS<br>1719 Druid Hill Ave.                                        |  |                                                                                |                                                                                                                                                      |                                                                                                 |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4411 IMMEDIATE CAUSE (a) Ruptured Thoracic Aneurysm<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Cardiovascular Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Primary Hypertension<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                                                                                                                   |                                                                                                                                                             |                                                                        |  |                                                                                |                                                                                                                                                      |                                                                                                 |                                                                                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                           |                                                                                                                                   |                                                                                                                                                             |                                                                        |  |                                                                                |                                                                                                                                                      |                                                                                                 |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                        |                                                                                                                                   |                                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                 |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                       |                                                                                                                                   |                                                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                                                      |                                                                                                 |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                   |                                                                                                                                   |                                                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                                                      |                                                                                                 |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/21, 1982, to 9/21, 1982, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                       |                                                                                                                                   |                                                                                                                                                             |                                                                        |  |                                                                                |                                                                                                                                                      |                                                                                                 |                                                                                                                            |
| 22b. SIGNATURE<br>K J Williams                                                                                                                                                                                                                                                                                                                |                                                                                                                                   |                                                                                                                                                             |                                                                        |  |                                                                                | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED                                                                                                           |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>K J Williams                                                                                                                                                                                                                                                                                         |                                                                                                                                   |                                                                                                                                                             |                                                                        |  |                                                                                | 22e. ADDRESS<br>4200 EDMONDSON AVE Baltimore                                                                                                         |                                                                                                 |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                           |                                                                                                                                   |                                                                                                                                                             | 23b. DATE<br>9/25/82                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem.                             |                                                                                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                                     |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME<br>Chas. A. Rice FHPA 1300 Eutaw Pl.                                                                                                                                                                                                                                                                             |                                                                                                                                   |                                                                                                                                                             |                                                                        |  |                                                                                | 25a. DATE REC'D. BY REGISTRAR<br>SEP 22 1982                                                                                                         |                                                                                                 |                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                   |                                                                                                                                                             |                                                                        |  |                                                                                | 25b. REGISTRAR'S SIGNATURE<br>John J. Conner                                                                                                         |                                                                                                 |                                                                                                                            |

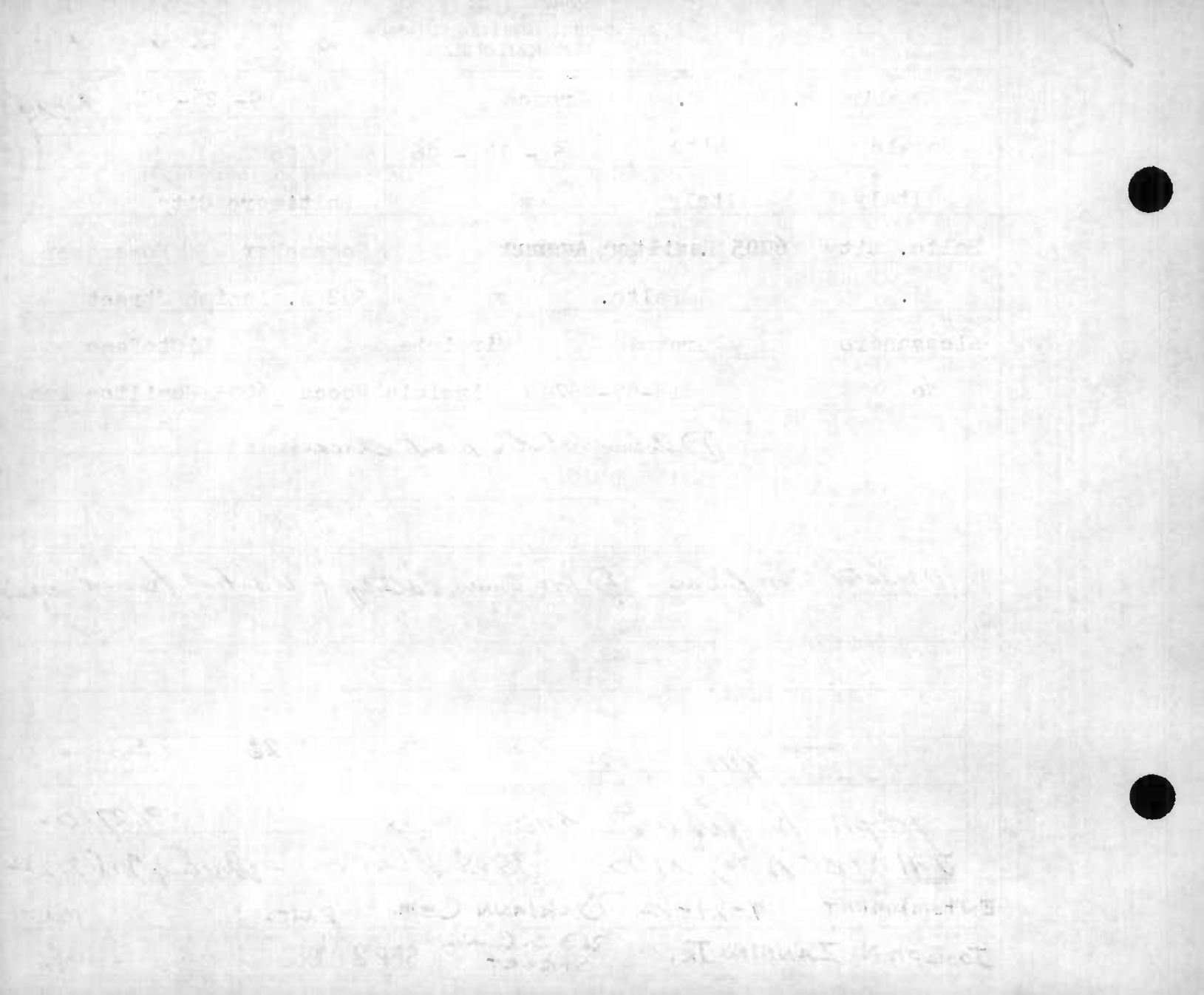


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

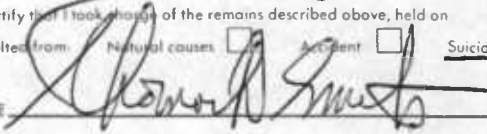

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                           |  |                                                                                                                                          |  | 8 2 2 3 5 6 1<br>REG. NO.                                                                                                                                   |  |                                                                                                                                       |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                                       |                                              |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Evelina M. Tronca</b>                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                          |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9-26-82</b>                                                                                                       |  | 2b. HOUR<br><b>9:30 am</b>                                                                                                            |                                              |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br><b>White</b>                                                                                                                  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5-14-06</b>                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.                                                                                     |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Italy</b>                                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Italy</b>                                                                                             |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                                     |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>Balto. City</b>                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6005 Hamilton Avenue</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>                                                                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Homemaker</b>                                                                                 |                                              |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                       |  | 13b. COUNTY<br><b>Balto.</b>                                                                                                             |  | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                                                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Alessandro Grampa</b>                                                                                                                                                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Virginia Distefano</b>                                                               |  |                                                                                                                                                             |  |                                                                                                                                       |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO.<br><b>213-07-4570</b>                                                                                           |  | 17. INFORMANT ADDRESS<br><b>Virginia Rocca 6005 Hamilton Ave</b>                                                                                            |  |                                                                                                                                       |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4140</b> IMMEDIATE CAUSE (a) <b>(1) Acute subarachnoid hemorrhage.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                            |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>(1) Myocardial Conduction System (2) Poss. Chronic Pathology + Ventricular Fibrillation</b>                                                                                                                             |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                                       |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |  | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                                       |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                                       |                                              |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>8/90</b> , 19 <b>78</b> , to <b>9/26</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>9/11/82</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                                       |                                              |
| 22b. SIGNATURE<br><b>Joseph B. Liberto, MD</b>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                          |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>9/27/82</b>                                                                                                    |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOSEPH B. LIBERTO, M.D.</b>                                                                                                                                                                                                                                                                                        |  |                                                                                                                                          |  | 22e. ADDRESS<br><b>3508 BANK ST. - Baltimore Md 21224</b>                                                                                                   |  |                                                                                                                                       |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Entombment</b>                                                                                                                                                                                                                                                                                                           |  | 23b. DATE<br><b>9-29-82</b>                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oaklawn Cem.</b>                                                                                                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto Md.</b>                                                                        |                                              |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Joseph N. ZANNINO JR. 263 S. Conkling Street</b>                                                                                                                                                                                                                                                                    |  |                                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 28 1982</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connelley</b>                                                                                |                                              |





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 2 3 5 6 2

|                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                    |                                                   |                                                                                                                                                                        |                                |                                                                                      |  |                                                                                                                     |                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|--------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Robert John Tuite                                                                                                                                                                                                                                                                                                                                                                                    |                  |                                                                                                                                    | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>8 22 1982 |                                                                                                                                                                        |                                | 2b. HOUR<br>M                                                                        |  |                                                                                                                     |                                              |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                              | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 26, 1954                                                                                | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>28 YRS.     | IF UNDER 1 YR.<br>MONTHS DAYS                                                                                                                                          | IF UNDER 24 HRS.<br>HOURS MIN. | 2c. DATE PRONOUNCED DEAD<br>8 22 1982                                                |  |                                                                                                                     | 2d. HOUR<br>a. 11:44<br>M                    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore Md.                                                                                                                                                                                                                                                                                                                                                                                  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                             |                                                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                          |  |                                                                                                                     |                                              |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                      |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>507 S. Grundy Street |                                                   |                                                                                                                                                                        |                                | 12a. USUAL OCCUPATION (TYPE OF WORK)<br>FOR MOST OF WORKING LIFE<br>Auto Mechanic    |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                   |                                              |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                      |                  | 13b. COUNTY<br>Howard                                                                                                              |                                                   | 13c. CITY OR TOWN<br>Ellicott City                                                                                                                                     |                                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>9898 Frederick Road                                                                          |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Louis Tuite                                                                                                                                                                                                                                                                                                                                                                                       |                  |                                                                                                                                    |                                                   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>late June Burrows                                                                                                     |                                |                                                                                      |  |                                                                                                                     |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                       |                  | 16b. SOCIAL SECURITY NO.<br>214 62 1582                                                                                            |                                                   | 17. INFORMANT<br>ADDRESS<br>Louis Tuite 9898 Frederick Rd Ellicott City                                                                                                |                                |                                                                                      |  |                                                                                                                     |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Carbon Monoxide Intoxication<br>9520<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF                                                                         |                  |                                                                                                                                    |                                                   |                                                                                                                                                                        |                                |                                                                                      |  |                                                                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                         |                  |                                                                                                                                    |                                                   |                                                                                                                                                                        |                                |                                                                                      |  |                                                                                                                     |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                      |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                  |                                                   |                                                                                                                                                                        |                                |                                                                                      |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |                                              |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                              |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. 8 22 1982                                                                |                                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject inhaled exhaust fumes from auto                                               |                                |                                                                                      |  |                                                                                                                     |                                              |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                        |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>Garage                                                              |                                                   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>507 S. Grundy Street, Baltimore, Maryland                                                                         |                                |                                                                                      |  |                                                                                                                     |                                              |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .<br>Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                  |                                                                                                                                    |                                                   |                                                                                                                                                                        |                                |                                                                                      |  |                                                                                                                     |                                              |
| ACTUAL SIGNATURE<br>                                                                                                                                                                                                                                                                                                                                     |                  | EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Thomas D. Smith, M.D.                                                                        |                                                   | TITLE (SPECIFY)<br>M.D. Deputy Chief                                                                                                                                   |                                | MEDICAL EXAMINER                                                                     |  | DATE SIGNED<br>8-23-82                                                                                              |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK ONE)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                    |                  | 23b. DATE<br>Aug 26, 1982                                                                                                          |                                                   | 23c. NAME OF CEMETERY OR CREMATORY<br>Crestlawn                                                                                                                        |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Howard, Maryland                       |  |                                                                                                                     |                                              |
| 24. FUNERAL DIRECTOR<br>Harry H Witzke                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                    |                                                   | ADDRESS<br>4112 Columbia Rd Ellicott City                                                                                                                              |                                | 25a. DATE REC'D. BY REGISTRAR<br>AUG 24 1982                                         |  | 25b. REGISTRAR'S SIGNATURE<br> |                                              |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 20 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_



Date: 10-10-1948

Reference No. U.S.A.

And: 10-10-1948

10-10-1948 10-10-1948 10-10-1948

10-10-1948 10-10-1948 10-10-1948

10-10-1948 10-10-1948 10-10-1948

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10-10-1948 10-10-1948 10-10-1948

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1301 BP 22

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                               |  | 8 2 2 3 5 6 3<br>REG. NO.                                                                                                                                  |  |                                                                                                                            |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Cleaster TUNCTSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                               |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 8, 1982</b>                                                                                            |  | 2b. HOUR<br><b>6:30<sup>a</sup> M</b>                                                                                      |                                              |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>Black</b>                                                                                                                       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 17 13</b>                                                                                                      |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.                                                                          |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. Carolina</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                    |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWE <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                          |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                              |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                               |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                            |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                      |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Cleaster Tunstson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Irene</b>                                                                                              |  |                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>N/A</b>                                                                         |  | 17. INFORMANT<br>ADDRESS<br><b>Leon Tunctson 1909 N. Longwood St.</b>                                                                                      |  |                                                                                                                            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>5850 IMMEDIATE CAUSE (a) Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Uremia; Sepsis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(c) <b>Chronic Renal Failure</b>                                                                                                                                             |  |                                                                                                                                               |  |                                                                                                                                                            |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                               |  |                                                                                                                                                            |  |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                              |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                              |  |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                          |  |                                                                                                                            |                                              |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 28</b> , 19 <b>82</b> , to <b>September 8</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>September 8</b> , 19 <b>82</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |                                                                                                                                               |  |                                                                                                                                                            |  |                                                                                                                            |                                              |
| 22b. SIGNATURE<br><b>Allan J. Chircus</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                               |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c. DATE SIGNED<br><b>9/8/82</b>                                                                                          |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Allan J. Chircus, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                               |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>                                                                                                       |  |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 23b. DATE<br><b>9/11/82</b>                                                                                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cem</b>                                                                                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                                                         |                                              |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                               |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 10 1982</b>                                                                                                        |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canine</b>                                                                        |                                              |

Allen J. Chiles, M.D. c/o Marvin & General Hospital

September 8

August 24

September 8

Chronic renal failure  
Uremic azotemia  
Cardiopulmonary arrest

Marvin General Hospital

Baltimore City

September 8, 1985

URGENT

Transfer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

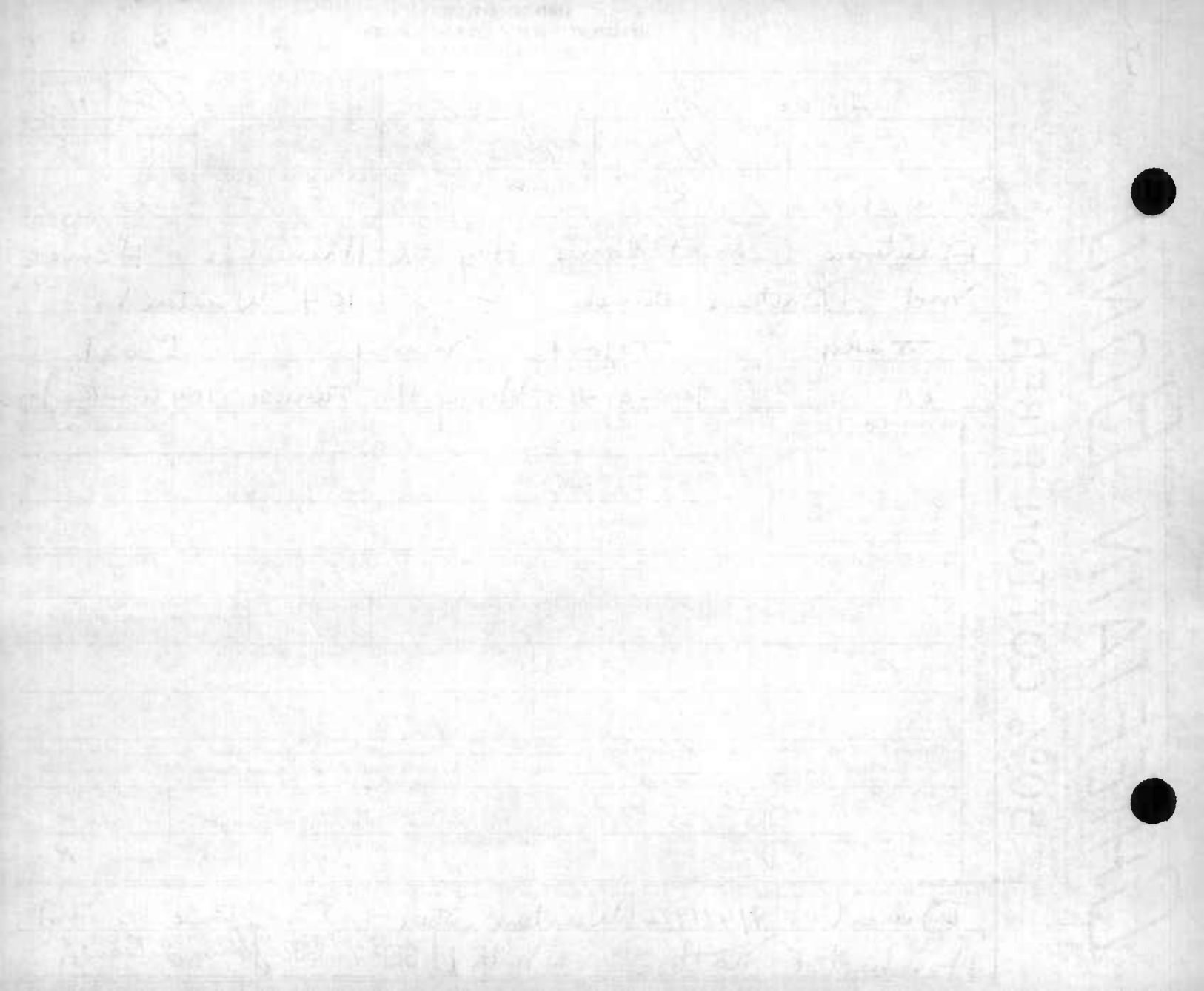
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                           |  |                                                                                                                                          |  |                                                                                                                                                                                                                   |  |                                                                                                 |  |                                                                                                                               |  | 8 2 2 3 5 6 4<br>REG. NO.                            |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Alice M. Turner</b>                                                                                                                                                                                                                                                                     |  |                                                                                                                                          |  |                                                                                                                                                                                                                   |  | 2a. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>11</b> YEAR <b>1982</b>                              |  |                                                                                                                               |  | 2b. HOUR <b>4:35</b> AM                              |  |  |  |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br><b>N V</b>                                                                                                                    |  | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>20</b> YEAR <b>1996</b>                                                                                                                                                |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b>                                                    |  | IF UNDER 1 YEAR<br>MONTHS <b>YES</b> DAYS <b>YES</b>                                                                          |  | IF UNDER 24 HRS.<br>HOURS <b>YES</b> MIN. <b>YES</b> |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                                                                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |                                                                                                                               |  |                                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Saint Agnes Hospital</b> |  |                                                                                                                                                                                                                   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                                                                              |  |                                                      |  |  |  |
| 13a. STATE<br><b>md.</b>                                                                                                                                                                                                                                                                                                       |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                          |  | 13c. CITY OR TOWN<br><b>Catonsville</b>                                                                                                                                                                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>104 Winters Lane</b> 21228                                                                          |  |                                                      |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>John</b> MIDDLE <b>Tagoud</b> LAST <b>Tagoud</b>                                                                                                                                                                                                                                                 |  |                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mary</b> MIDDLE <b>Bond</b> LAST <b>Bond</b>                                                                                                                                 |  |                                                                                                 |  |                                                                                                                               |  |                                                      |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-09-2378</b>                                                            |  | 17. INFORMANT<br><b>Henry H. Turner</b>                                                                                                                                                                           |  |                                                                                                 |  | ADDRESS<br><b>104 Winters Lane</b>                                                                                            |  |                                                      |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4415</b> IMMEDIATE CAUSE (a) <b>Cardiorespiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Dilatating aortic aneurysm type III</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASEVD</b>         |  |                                                                                                                                          |  |                                                                                                                                                                                                                   |  |                                                                                                 |  |                                                                                                                               |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH      |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                            |  |                                                                                                                                          |  |                                                                                                                                                                                                                   |  |                                                                                                 |  |                                                                                                                               |  |                                                      |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |  |                                                                                                                                                                                                                   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                      |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                    |  |                                                                                                 |  |                                                                                                                               |  |                                                      |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                 |  |                                                                                                 |  |                                                                                                                               |  |                                                      |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                          |  |                                                                                                                                                                                                                   |  |                                                                                                 |  |                                                                                                                               |  |                                                      |  |  |  |
| 22b. SIGNATURE<br><b>Manojan P. Singh</b>                                                                                                                                                                                                                                                                                      |  |                                                                                                                                          |  | DEGREE<br><b>PHYSICIAN</b> <input type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input checked="" type="checkbox"/><br>DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> |  |                                                                                                 |  | 22c. DATE SIGNED<br><b>9/11/82 4:35 AM</b>                                                                                    |  |                                                      |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. SINGH</b>                                                                                                                                                                                                                                                                       |  |                                                                                                                                          |  | 22e. ADDRESS<br><b>Caton Ave<br/>St. Agnes Hosp. Baltimore, MD.</b>                                                                                                                                               |  |                                                                                                 |  |                                                                                                                               |  |                                                      |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                  |  | 23b. DATE<br><b>9/14/1982</b>                                                                                                            |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Winters Star</b>                                                                                                                                                         |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Co.</b> STATE <b>md.</b>               |  |                                                                                                                               |  |                                                      |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>H. Robert E. Huth</b> ADDRESS <b>3055 W. North</b>                                                                                                                                                                                                                                             |  |                                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR (SE) REGISTRAR'S SIGNATURE<br><b>SEP 7 1982 John J. Connel</b>                                                                                                                      |  |                                                                                                 |  |                                                                                                                               |  |                                                      |  |  |  |

BP



2025 COLLECTION 2002

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                               |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                                           |  |                                                                                                                                       |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                             |  | 8 2                                                                                                                                      |  | 2 3 5 6 5                                                                                                                                                   |  | REG. NO.                                                                                                                                  |  |                                                                                                                                       |                                              |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Garland</b>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                          |  | FIRST <b>BB</b> MIDDLE <b>TYSON</b> LAST                                                                                                                    |  | 2a. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>3</b> YEAR <b>82</b>                                                                           |  | 2b. HOUR <b>340 P.M.</b>                                                                                                              |                                              |
| 3. SEX <b>M</b>                                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE <b>Black</b>                                                                                                                     |  | 5. DATE OF BIRTH<br>MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/>              |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. <input checked="" type="checkbox"/> MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> |  | IF UNDER 1 YEAR<br>IF UNDER 24 HRS.                                                                                                   |                                              |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                                  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                                                                          |  |                                                                                                                                       |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hosp.</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                          |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                     |                                              |
| 13a. STATE <b>MD</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                          |  | 13b. CITY OR TOWN <b>Edgewater</b>                                                                                                                          |  | 13c. STREET ADDRESS<br><b>7209 Orth Rd</b>                                                                                                |  |                                                                                                                                       |                                              |
| 14. FATHER'S NAME<br>FIRST <b>Garland</b> MIDDLE <b>E.</b> LAST <b>Powell</b>                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Priscilla</b> MIDDLE <b>Tyson</b> LAST                                                                                 |  |                                                                                                                                           |  |                                                                                                                                       |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>N/A</b>                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>                                                                                                                      |  | 17. INFORMANT<br><b>Jeanette Tyson</b> ADDRESS <b>7209 Orth Rd.</b>                                                                       |  |                                                                                                                                       |                                              |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MULTIPLE CONGENITAL ANOMALIES</b><br><b>7597</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                                           |  |                                                                                                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____                                                                                                                                                                                                                                         |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                                           |  |                                                                                                                                       |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                                           |  |                                                                                                                                       |                                              |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                                           |  |                                                                                                                                       |                                              |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.                                                                 |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                                           |  |                                                                                                                                       |                                              |
| 22a. SIGNATURE<br><b>James R. Miller MD</b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                          |  |                                                                                                                                                             |  | DEGREE<br><b>MD</b>                                                                                                                       |  | 22c. DATE SIGNED<br><b>9-3-82</b>                                                                                                     |                                              |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES R. MILLER, MD</b>                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                          |  | 22e. ADDRESS<br><b>BALTIMORE CITY HOSP.</b>                                                                                                                 |  |                                                                                                                                           |  |                                                                                                                                       |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br><b>9/9/82</b>                                                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion Cem.</b>                                                                                                  |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore, Md.</b> COUNTY STATE                                                                          |  |                                                                                                                                       |                                              |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm C. March F/H, Inc.</b> ADDRESS <b>1101 E. North Ave.</b>                                                                                                                                                                                                                                                                                        |  |                                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 10 1982</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Smith</b>                                                                                        |  |                                                                                                                                       |                                              |

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

2. In the second part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

3. The third part of the paper is devoted to a discussion of the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

4. In the fourth part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

5. The fifth part of the paper is devoted to a discussion of the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

6. In the sixth part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

7. The seventh part of the paper is devoted to a discussion of the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

8. In the eighth part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

9. The ninth part of the paper is devoted to a discussion of the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.

10. In the tenth part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the laws of conservation of energy and momentum.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 5 6 6

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                    |                                                        |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Frieda Unger</b>                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                    | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09-30-82</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>2:30 A</b> M                                                                     |  |                                                                                                                            |                                              |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br><b>WHITE</b>                                                                                                            |                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10-XX-08</b>                                                                                                       |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.                                               |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                        |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>                                                                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                         |                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto City</b> MD.                                   |  |                                                                                                                            |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>Balto</b>                                                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital</b> |                                                        |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>A T HOME</b>                                                                       |                                              |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                           |  | 13b. COUNTY<br><b>BALTIMORE</b>                                                                                                    |                                                        | 13c. CITY OR TOWN<br><b>Randallstown</b>                                                                                                                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>APT. 307 3801 Schaper Dr</b>                                                                     |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Philip Friedman</b>                                                                                                                                                                                                                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Gussie Raffalow</b>                                                            |                                                        | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br><b>XXXXXX NO</b>                                                             |  | 16b. SOCIAL SECURITY NO.<br><b>067 246459</b>                                                   |  | 17. INFORMANT<br><b>STEPHEN UNGER SS 9704 SOUTHALL RD. RANDALLSTOWN, MD 21133</b>                                          |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>0381 IMMEDIATE CAUSE (a) Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Septic shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Staph/Strep septicemia</b> |  |                                                                                                                                    |                                                        |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Breast CA, Mild Diabetes</b>                                                                                                                                                                                                                            |  |                                                                                                                                    |                                                        |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |                                                        |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                         |                                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                 |  |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                             |                                                        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                            |                                              |
| 22a. I certify that (I (this hospital) attended the deceased from <b>9/28</b> , 19 <b>82</b> , to <b>9/30</b> , 19 <b>82</b> , and that (I (we) last saw the deceased alive on <b>9/30</b> , 19 <b>82</b> , and that (I (we) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                              |  |                                                                                                                                    |                                                        |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |                                              |
| 22b. SIGNATURE<br><b>M. FELDMAN MD</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                    |                                                        | DEGREE<br><b>M. FELDMAN MD</b>                                                                                                                              |  |                                                                                                 |  | 22c. DATE SIGNED<br><b>9/30/82</b>                                                                                         |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. FELDMAN MD</b>                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                    |                                                        | 22e. ADDRESS<br><b>Mercy Hospital</b>                                                                                                                       |  |                                                                                                 |  |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>REMOVAL/BURIAL</b>                                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br><b>OCT. 1, 1982</b>                                                                                                   |                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. HEBRON</b>                                                                                                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>FLUSHING LI NEW YORK</b>                       |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 6 1982</b>                                                                         |                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                    |                                                        | 25b. ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>                                                                                               |  |                                                                                                 |  |                                                                                                                            |                                              |

BP

U.S. 20

U.S. DEPARTMENT OF THE ARMY  
HEADQUARTERS  
WASHINGTON, D.C.



CHIEF

20% COTTON

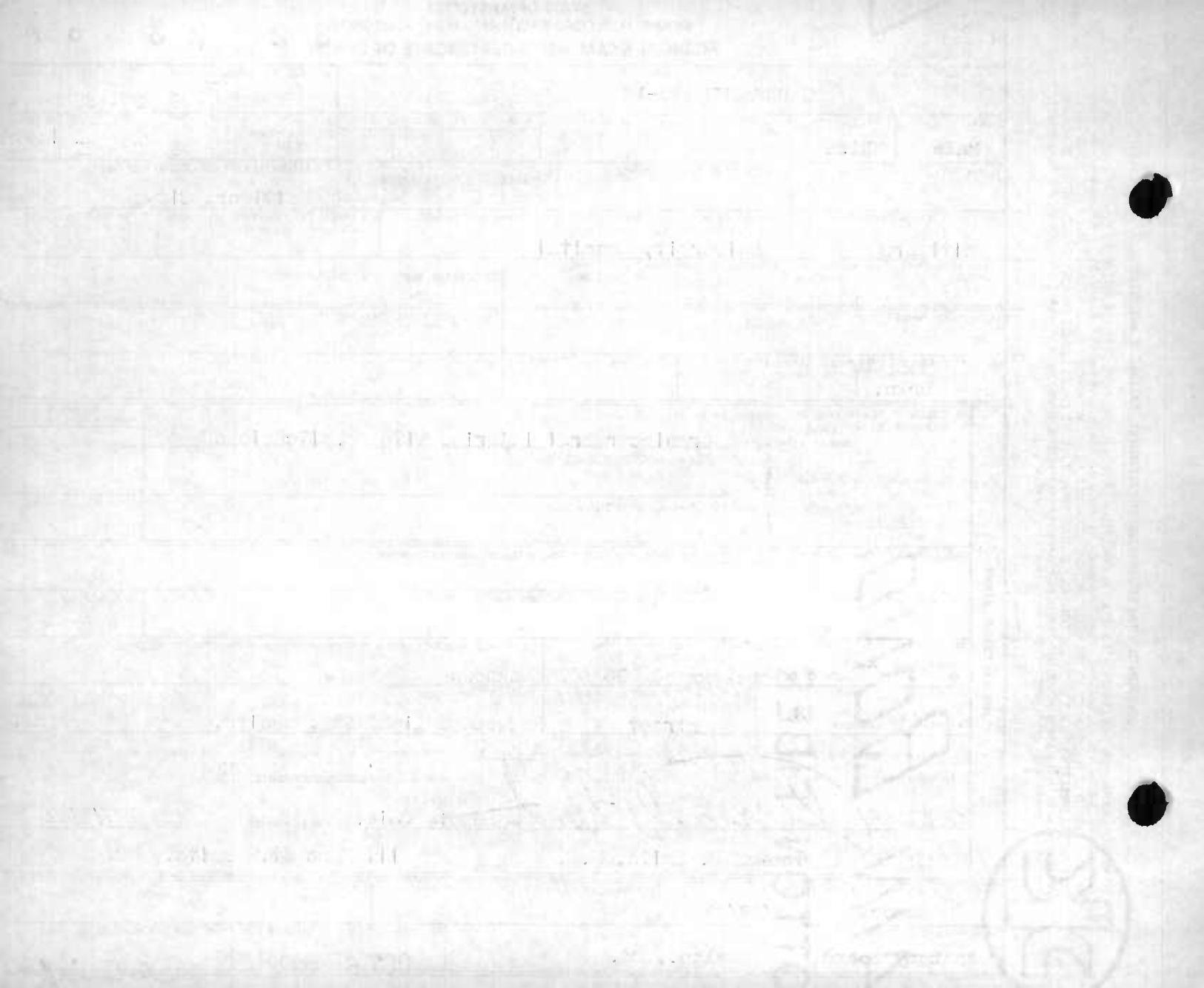


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                |  |                                                                                                         |                                                                                                                                                                                                      |                                                               |                                                   |                                                                               |                                                          |                                      |                     | REG. NO. 2 2 3 5 6 7                                                |         |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------|-------------------------------------------------------------------------------|----------------------------------------------------------|--------------------------------------|---------------------|---------------------------------------------------------------------|---------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                         | 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                     |                                                               | FIRST MIDDLE LAST                                 |                                                                               |                                                          | 2a. DATE KNOWN OF DEATH              |                     | 2b. HOUR                                                            |         |  |
|                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                         | UNKNOWN #82-18                                                                                                                                                                                       |                                                               |                                                   |                                                                               |                                                          | XX MONTH DAY YEAR                    |                     | M                                                                   |         |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE                                                                                                 |                                                                                                                                                                                                      | 5. DATE OF BIRTH                                              |                                                   | 6. AGE (IN YEARS)                                                             |                                                          | IF UNDER 1 YR.                       |                     | IF UNDER 24 HRS.                                                    |         |  |
| Male                                                                                                                                                                                                                                                                                                                                                                                   |  | White                                                                                                   |                                                                                                                                                                                                      | MONTH DAY YEAR                                                |                                                   | LAST BIRTHDAY YRS.                                                            |                                                          | MONTHS DAYS                          |                     | HOURS MIN.                                                          |         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                            |                                                                                                                                                                                                      | 8. MARRIED                                                    |                                                   | NEVER MARRIED                                                                 |                                                          | WIDOWED                              |                     | DIVORCED                                                            |         |  |
|                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                         |                                                                                                                                                                                                      |                                                               |                                                   |                                                                               |                                                          |                                      |                     |                                                                     |         |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                                                                      | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                   | 12b. KIND OF BUSINESS OR INDUSTRY                                             |                                                          | 9. BALTIMORE CITY OR COUNTY OF DEATH |                     | MD.                                                                 |         |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                              |  | University Hospital                                                                                     |                                                                                                                                                                                                      |                                                               |                                                   |                                                                               |                                                          | Baltimore City,                      |                     |                                                                     |         |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                         | 13b. COUNTY                                                                                                                                                                                          |                                                               | 13c. CITY OR TOWN                                 |                                                                               | 13d. INSIDE CITY LIMITS?                                 |                                      | 13e. STREET ADDRESS |                                                                     |         |  |
|                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                         |                                                                                                                                                                                                      |                                                               |                                                   |                                                                               | YES <input type="checkbox"/> NO <input type="checkbox"/> |                                      |                     |                                                                     |         |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                         | 15. MOTHER'S MAIDEN NAME                                                                                                                                                                             |                                                               | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?      |                                                                               | 16b. SOCIAL SECURITY NO.                                 |                                      | 17. INFORMANT       |                                                                     | ADDRESS |  |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                         | FIRST MIDDLE LAST                                                                                                                                                                                    |                                                               | (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) |                                                                               |                                                          |                                      |                     |                                                                     |         |  |
| Unkn.                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                         |                                                                                                                                                                                                      |                                                               |                                                   |                                                                               |                                                          |                                      |                     |                                                                     |         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>9889 IMMEDIATE CAUSE (a) <u>Cranio-cerebral injuries with complications</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                                                         |                                                                                                                                                                                                      |                                                               |                                                   |                                                                               |                                                          |                                      |                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |         |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                                                                                                                                                                                         |  |                                                                                                         |                                                                                                                                                                                                      |                                                               |                                                   |                                                                               |                                                          |                                      |                     |                                                                     |         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                                                                    |                                                               |                                                   |                                                                               |                                                          | 20. AUTOPSY?                         |                     | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |         |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                         |  |                                                                                                         | 21b. TIME OF INJURY                                                                                                                                                                                  |                                                               |                                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                                          |                                      |                     |                                                                     |         |  |
| 6:28xx 8 28 1982                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                         | Unknown                                                                                                                                                                                              |                                                               |                                                   |                                                                               |                                                          |                                      |                     |                                                                     |         |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                                                                          |                                                               |                                                   | 21f. LOCATION                                                                 |                                                          |                                      | 21g. CITY OR TOWN   |                                                                     |         |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                           |  |                                                                                                         | street                                                                                                                                                                                               |                                                               |                                                   | Redwood & Light Sts.                                                          |                                                          |                                      | Balto.              |                                                                     |         |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:                                                                                                                                                      |  |                                                                                                         | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> |                                                               |                                                   | TITLE (SPECIFY)                                                               |                                                          |                                      | DATE SIGNED         |                                                                     |         |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                         | Thomas D. Smith, M.D.                                                                                                                                                                                |                                                               |                                                   | Deputy Chief                                                                  |                                                          |                                      | 9/9/82              |                                                                     |         |  |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                         | ADDRESS                                                                                                                                                                                              |                                                               |                                                   | III Penn St. Balto., MD.                                                      |                                                          |                                      |                     |                                                                     |         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                         | 23b. DATE                                                                                                                                                                                            |                                                               | 23c. NAME OF CEMETERY OR CREMATORY                |                                                                               |                                                          | 23d. LOCATION                        |                     | COUNTY STATE                                                        |         |  |
| Removal                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                         | 9/28/82                                                                                                                                                                                              |                                                               |                                                   |                                                                               |                                                          | CITY OR TOWN                         |                     |                                                                     |         |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                         |                                                                                                                                                                                                      |                                                               |                                                   | 25a. DATE REC'D. BY REGISTRAR                                                 |                                                          | 25b. REGISTRAR'S SIGNATURE           |                     |                                                                     |         |  |
| NAME                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                         |                                                                                                                                                                                                      |                                                               |                                                   | OCT 6 1982                                                                    |                                                          | John J. Conner                       |                     |                                                                     |         |  |
| Anatomy Board                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                         |                                                                                                                                                                                                      |                                                               |                                                   | ADDRESS                                                                       |                                                          |                                      |                     |                                                                     |         |  |
| Balto., Md.                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                         |                                                                                                                                                                                                      |                                                               |                                                   |                                                                               |                                                          |                                      |                     |                                                                     |         |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                          |  | 8 2 2 3 5 6 8                                                                                                                                               |  |                                                                                                                                          |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                          |  | REG. NO.                                                                                                                                                    |  |                                                                                                                                          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Bernardette W. Urban</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                          |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>9-24-82</b>                                                                                                          |  |                                                                                                                                          |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                          |  | 4. RACE<br><b>WHITE</b>                                                                                                                                     |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>6 12 25</b>                                                                                        |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS.                                                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                            |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALT. CITY.</b> MD.                                                                           |  |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GOOD SAMARITAN HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>                                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                        |  |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                     |  | 13b. CITY OR TOWN<br><b>Harford</b>                                                                                                      |  | 13c. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>                                               |  | 13d. STREET ADDRESS<br><b>406 LINWOOD AV.</b>                                                                                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Bernard Wilkens</b>                                                                                                                                                                                                                                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Elizabeth Fell</b>                                                                      |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>                                                  |  | 16b. SOCIAL SECURITY NO.<br><b>219-20-5597</b>                                                                                           |  |
| 17. INFORMANT ADDRESS<br><b>Charles F. Urban 406 Linwood Ave. Bel Air, Md.</b>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1539 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ADVANCED METASTATIC</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CARCINOMA OF COLON</b> |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                                          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).                                                                                                                                                                                                                                                                          |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                                          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |  | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>                                                          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER).                                                                                                                                                                                                                                                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                                          |  |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                      |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                                          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-10-82</b> , to <b>9-24-82</b> , that (I) (we) last saw the deceased alive on <b>9-24-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (I did not) view the body after death.                                                                            |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                                          |  |
| 22b. SIGNATURE<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                          |  | 22c. DATE SIGNED<br><b>9-24-82</b>                                                                                                                          |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. ZAN MIN</b>                                                                              |  |
| 22e. ADDRESS<br><b>5601 LOCH RAVEN BLVD, BALT.</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                          |  |                                                                                                                                                             |  |                                                                                                                                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br><b>9-28-82</b>                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bel Air Mem. Gardens</b>                                                                                           |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Bel Air Harford Md.</b>                                                                    |  |
| 24. FUNERAL DIRECTOR NAME<br><b>E.F. LASSAHN FUNERAL HOME</b>                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                          |  | 25. DATE REC'D. BY REGISTRAR OF REGISTRAR'S SIGNATURE<br><b>11750 Belair Rd. Kingsville OCT 4 1982 [Signature]</b>                                          |  |                                                                                                                                          |  |

MEDICAL CERTIFICATION



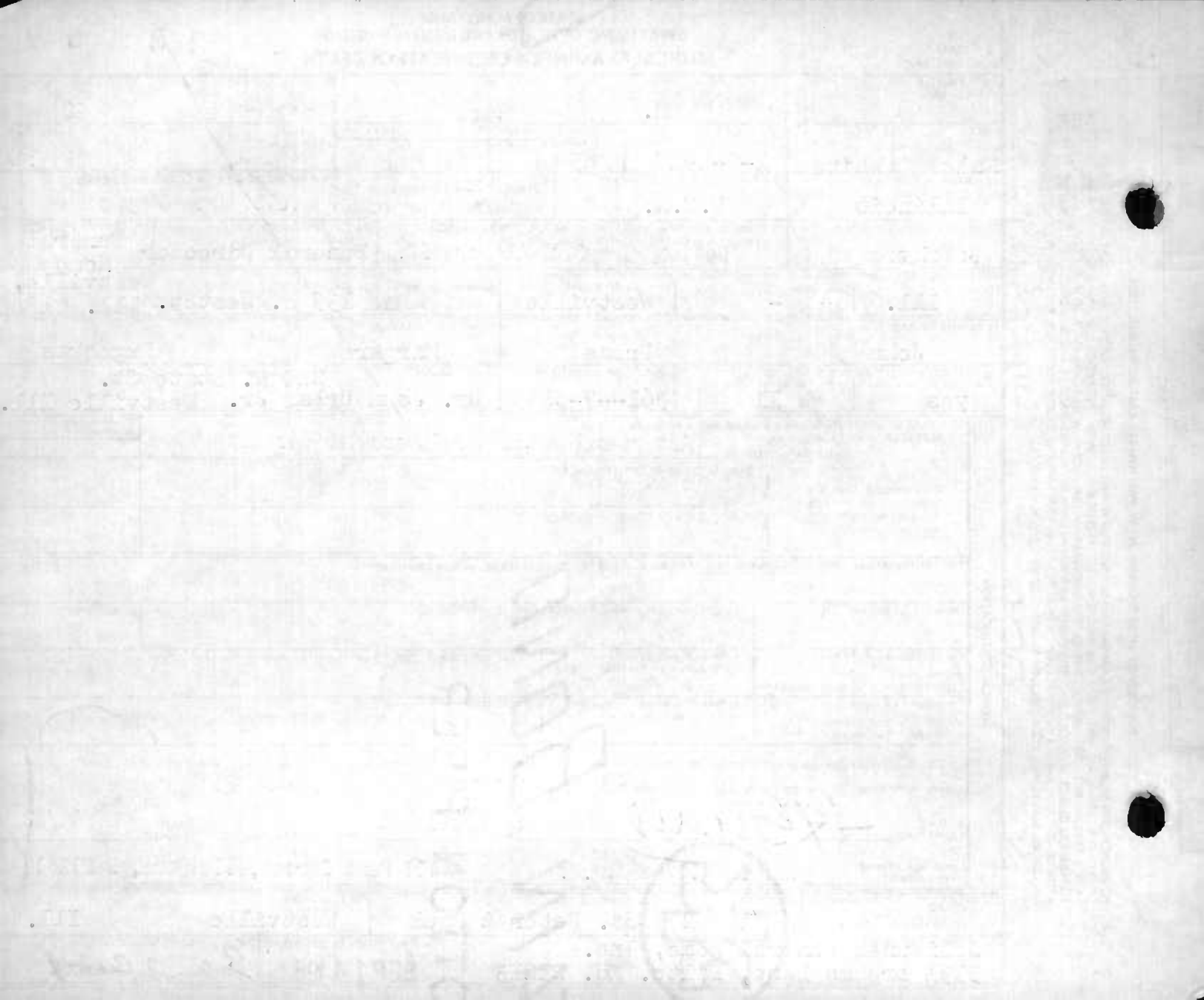


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                  |  | REG. NO. 2 2 3 5 6 9                                                                                     |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                  |  |                                                                                                          |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Cyril M. Urbas</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                  |  | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>9 8 19 82</b> |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br><b>White</b>                                                                                                                        |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>1-9-1917</b>                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>65 YRS.</b>                                               |  | IF UNDER 1 YR. MONTHS DAYS<br><b>0 0</b>                                         |  | 2b. DATE PRONOUNCED DEAD MONTH DAY YEAR<br><b>9 9 19 82</b>                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Illinois</b>                                                                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                                |  |                                                                                  |  |                                                                                                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holiday Inn/301W Lombard St.</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Funeral Director</b>     |  | 12b. KIND OF BUSINESS<br><b>Funeral Home</b>                                     |  |                                                                                                          |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                  |  |                                                                                                          |  |
| 13a. STATE<br><b>Ill.</b>                                                                                                                                                                                                                                                                                                                                                                                                                |  | 13b. COUNTY<br><b>-</b>                                                                                                                        |  | 13c. CITY OR TOWN<br><b>Westville</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>135 N. WestSt. Ill. 61883</b>                          |  | 13f. CITY OR TOWN<br><b>Westville, Ill.</b>                                                              |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John Urbas</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Margaret Lugoskas</b>                                                                                      |  |                                                                                              |  |                                                                                  |  |                                                                                                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>yes</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.<br><b>361-07-5485</b>                                                                                                              |  | 17. INFORMANT<br><b>Dr. John Urbas Jr.</b>                                                   |  | 220 N. State St.<br><b>Westville Ill.</b>                                        |  |                                                                                                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4292</b><br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                             |  |                                                                                                                                                |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                             |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                  |  |                                                                                                          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                           |  |                                                                                              |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                                                                                          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                              |  |                                                                                  |  |                                                                                                          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                              |  |                                                                                  |  |                                                                                                          |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                                                                                                                                                |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                  |  |                                                                                                          |  |
| ACTUAL SIGNATURE<br><i>Hormez R. Guard</i>                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                |  | TITLE (SPECIFY)<br><b>Assistant</b>                                                                                                                         |  |                                                                                              |  | DATE SIGNED<br><b>9/10/82</b>                                                    |  |                                                                                                          |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Hormez R. Guard, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                |  | ADDRESS<br><b>111 Penn Street, Baltimore, MD 21201</b>                                                                                                      |  |                                                                                              |  |                                                                                  |  |                                                                                                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE<br><b>9/10/82</b>                                                                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Peter &amp; Paul</b>                                                                                           |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Westville Ill.</b>                             |  |                                                                                  |  |                                                                                                          |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>Scimunek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213</b>                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                |  |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 14 1982</b>                                          |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Conner</i>                              |  |                                                                                                          |  |

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B, show any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                          |                                                  |                                      |                                    |                 |  | 8 2 2 3 5 7 0                                                                  |  |                                                                |  |                                                                     |                    |                                   |                                              |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------|------------------------------------|-----------------|--|--------------------------------------------------------------------------------|--|----------------------------------------------------------------|--|---------------------------------------------------------------------|--------------------|-----------------------------------|----------------------------------------------|--|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                          |                                                  |                                      |                                    |                 |  | REG. NO.                                                                       |  |                                                                |  |                                                                     |                    |                                   |                                              |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                            |  |                                                                                                        |  |                                                                                                                                                          | 2a. DATE OF DEATH                                |                                      |                                    |                 |  | MONTH                                                                          |  | DAY                                                            |  | YEAR                                                                |                    | 2b. HOUR                          |                                              |  |  |
| John Valentine                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |  |                                                                                                                                                          |                                                  |                                      |                                    |                 |  | 09                                                                             |  | 05                                                             |  | 82                                                                  |                    | 9:50a                             |                                              |  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                         |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                                                                                         |                                                  | 6. AGE (IN YEARS, LAST BIRTHDAY)     |                                    | IF UNDER 1 YEAR |  | IF UNDER 24 HRS                                                                |  |                                                                |  |                                                                     |                    |                                   |                                              |  |  |
| Male                                                                                                                                                                                                                                                                                                           |  | Black                                                                                                  |  | 3 3 03                                                                                                                                                   |                                                  | 79 YRS.                              |                                    | MONTHS          |  | DAYS                                                                           |  | HOURS                                                          |  | MIN.                                                                |                    |                                   |                                              |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH |                                    |                 |  |                                                                                |  |                                                                |  |                                                                     |                    |                                   |                                              |  |  |
| Va.                                                                                                                                                                                                                                                                                                            |  | USA                                                                                                    |  |                                                                                                                                                          |                                                  | Baltimore MD.                        |                                    |                 |  |                                                                                |  |                                                                |  |                                                                     |                    |                                   |                                              |  |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                          |                                                  |                                      |                                    |                 |  |                                                                                |  |                                                                |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |                    | 12b. KIND OF BUSINESS OR INDUSTRY |                                              |  |  |
| Balto.                                                                                                                                                                                                                                                                                                         |  | Johns Hopkins Hospital                                                                                 |  |                                                                                                                                                          |                                                  |                                      |                                    |                 |  |                                                                                |  |                                                                |  |                                                                     |                    |                                   |                                              |  |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  |                                                                                                                                                          |                                                  |                                      |                                    |                 |  | 13b. COUNTY                                                                    |  | 13c. CITY OR TOWN                                              |  | 13d. INSIDE CITY LIMITS?                                            |                    | 13e. STREET ADDRESS               |                                              |  |  |
| Md.                                                                                                                                                                                                                                                                                                            |  |                                                                                                        |  |                                                                                                                                                          |                                                  |                                      |                                    |                 |  |                                                                                |  | Balto.                                                         |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                    | 1136 E. Fayette                   |                                              |  |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                          | 15. MOTHER'S MAIDEN NAME                         |                                      |                                    |                 |  |                                                                                |  |                                                                |  |                                                                     |                    |                                   |                                              |  |  |
| James W. Valentine                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                          | Alice Harrison                                   |                                      |                                    |                 |  |                                                                                |  |                                                                |  |                                                                     |                    |                                   |                                              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                          | 16b. SOCIAL SECURITY NO.                         |                                      |                                    |                 |  | 17. INFORMANT                                                                  |  |                                                                |  |                                                                     | ADDRESS            |                                   |                                              |  |  |
| No                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                          | 215-12-5593                                      |                                      |                                    |                 |  | Ethel V. Jackson                                                               |  |                                                                |  |                                                                     | 1136 W. Fayette St |                                   |                                              |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                          |                                                  |                                      |                                    |                 |  |                                                                                |  |                                                                |  |                                                                     |                    |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  |                                                                                                                                                          |                                                  |                                      |                                    |                 |  |                                                                                |  |                                                                |  |                                                                     |                    |                                   |                                              |  |  |
| IMMEDIATE CAUSE (a) Respiratory arrest                                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                          |                                                  |                                      |                                    |                 |  |                                                                                |  |                                                                |  |                                                                     |                    |                                   |                                              |  |  |
| 4321                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                          |                                                  |                                      |                                    |                 |  |                                                                                |  |                                                                |  |                                                                     |                    |                                   |                                              |  |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                 |  |                                                                                                        |  |                                                                                                                                                          |                                                  |                                      |                                    |                 |  |                                                                                |  |                                                                |  |                                                                     |                    |                                   |                                              |  |  |
| (b)                                                                                                                                                                                                                                                                                                            |  |                                                                                                        |  |                                                                                                                                                          |                                                  |                                      |                                    |                 |  |                                                                                |  |                                                                |  |                                                                     |                    |                                   |                                              |  |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                 |  |                                                                                                        |  |                                                                                                                                                          |                                                  |                                      |                                    |                 |  |                                                                                |  |                                                                |  |                                                                     |                    |                                   |                                              |  |  |
| (c)                                                                                                                                                                                                                                                                                                            |  |                                                                                                        |  |                                                                                                                                                          |                                                  |                                      |                                    |                 |  |                                                                                |  |                                                                |  |                                                                     |                    |                                   |                                              |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                          |                                                  |                                      |                                    |                 |  |                                                                                |  |                                                                |  |                                                                     |                    |                                   |                                              |  |  |
| Cerebral edema                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |  |                                                                                                                                                          |                                                  |                                      |                                    |                 |  |                                                                                |  |                                                                |  |                                                                     |                    |                                   |                                              |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |                                      |                                    |                 |  | 20a. AUTOPSY?                                                                  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                                                                     |                    |                                   |                                              |  |  |
| 8-30-82                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                          | Subdural hematoma                                |                                      |                                    |                 |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                                                                     |                    |                                   |                                              |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                          | 21b. TIME OF INJURY                              |                                      |                                    |                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |                                                                |  |                                                                     |                    |                                   |                                              |  |  |
|                                                                                                                                                                                                                                                                                                                |  |                                                                                                        |  |                                                                                                                                                          | HOUR A.M. MONTH DAY YEAR                         |                                      |                                    |                 |  |                                                                                |  |                                                                |  |                                                                     |                    |                                   |                                              |  |  |
|                                                                                                                                                                                                                                                                                                                |  |                                                                                                        |  |                                                                                                                                                          | P.M. 19                                          |                                      |                                    |                 |  |                                                                                |  |                                                                |  |                                                                     |                    |                                   |                                              |  |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                          | 21e. PLACE OF INJURY                             |                                      |                                    |                 |  | 21f. LOCATION                                                                  |  |                                                                |  |                                                                     |                    |                                   |                                              |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                          | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]   |                                      |                                    |                 |  | STREET CITY OR TOWN COUNTY STATE                                               |  |                                                                |  |                                                                     |                    |                                   |                                              |  |  |
|                                                                                                                                                                                                                                                                                                                |  |                                                                                                        |  |                                                                                                                                                          |                                                  |                                      |                                    |                 |  |                                                                                |  |                                                                |  |                                                                     |                    |                                   |                                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-95, 19 82, to 9-5, 19 82, that (I) (we) lost saw the deceased alive on 9-5, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |                                                  |                                      |                                    |                 |  |                                                                                |  |                                                                |  |                                                                     |                    |                                   |                                              |  |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |  |                                                                                                                                                          |                                                  |                                      |                                    |                 |  | DEGREE                                                                         |  |                                                                |  |                                                                     | 22c. DATE SIGNED   |                                   |                                              |  |  |
| Wearns                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                          |                                                  |                                      |                                    |                 |  |                                                                                |  |                                                                |  |                                                                     | 9-5-82             |                                   |                                              |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                          |  |                                                                                                        |  |                                                                                                                                                          |                                                  |                                      |                                    |                 |  | 22e. ADDRESS                                                                   |  |                                                                |  |                                                                     |                    |                                   |                                              |  |  |
| Wearns                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                          |                                                  |                                      |                                    |                 |  | SHH - D4768                                                                    |  |                                                                |  |                                                                     |                    |                                   |                                              |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                          | 23b. DATE                                        |                                      | 23c. NAME OF CEMETERY OR CREMATORY |                 |  |                                                                                |  | 23d. LOCATION                                                  |  |                                                                     |                    |                                   |                                              |  |  |
| Cremation                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                          | 9/7/82                                           |                                      | Westview Mem. Pk.                  |                 |  |                                                                                |  | Catonville, Md.                                                |  |                                                                     |                    |                                   |                                              |  |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                          |                                                  |                                      |                                    |                 |  | 25a. DATE REC'D. BY REGISTRAR                                                  |  |                                                                |  |                                                                     | 25b. SIGNATURE     |                                   |                                              |  |  |
| Wm C March F/H, Inc.                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                          |                                                  |                                      |                                    |                 |  | SEP 15 1982                                                                    |  |                                                                |  |                                                                     | John J. Smith      |                                   |                                              |  |  |
| NAME                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                          |                                                  |                                      |                                    |                 |  | ADDRESS                                                                        |  |                                                                |  |                                                                     |                    |                                   |                                              |  |  |
| Wm C March F/H, Inc.                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                          |                                                  |                                      |                                    |                 |  | 1101 E. North Ave                                                              |  |                                                                |  |                                                                     |                    |                                   |                                              |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                 |  | 8 2 2 3 5 7 1<br>REG. NO.                                                                                                                                   |  |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>FREDERIK VAN HOGENDORP</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                 |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9-11-82</b>                                                                                                       |  | 2b. HOUR<br><b>0830 hrs</b>                                                                                                |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br><b>White</b>                                                                                                                         |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11--10---1896</b>                                                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b><br>YRS. MONTHS DAYS HOURS MIN.                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>The Netherlands</b>                                                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE UNION MEMORIAL HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales</b>                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Real Estate</b>                                                                    |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                     |  | 13b. COUNTY                                                                                                                                     |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Leopold van Hogendorp</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                 |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sophia Rengers</b>                                                                                      |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                 |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>214-30-3412A</b>                                                                  |  | 17. INFORMANT ADDRESS<br><b>Mrs. K.D. van Hogendorp 114 W. Melrose Ave.</b>                                                                                 |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple CVAs</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. — 19                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                          |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/10</b> 19 <b>82</b> , to <b>9/11</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>9/11/82</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.                                                                     |  |                                                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>C. J. Huddleston MD.</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                 |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  | 22c. DATE SIGNED<br><b>9/11/82</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. J. HUDDLESTON</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                 |  | 22e. ADDRESS<br><b>Union Memorial Hospo</b>                                                                                                                 |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                        |  | 23b. DATE<br><b>9-14-82</b>                                                                                                                     |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b>                                                                                                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pikesville Baltimore Md</b>                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home 6500 York Rd 21212</b>                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                 |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 17 1982</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>                                                                        |  |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                         |  |                  |  |                                                                                                                                   |  |                                                                                                  |                                                                                                 |                                                                                                                                                             |                     | REG. NO. 2 3 5 7 2                                                                  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                  |  |                                                                                                                                   |  |                                                                                                  |                                                                                                 |                                                                                                                                                             |                     |                                                                                     |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>ERIC B. VENABLE                                                                                                                                                                                                                                                                                                                                                                           |  |                  |  |                                                                                                                                   |  |                                                                                                  | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>9-11-82 |                                                                                                                                                             | 2b. HOUR<br>M       |                                                                                     |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br>Black |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>7 31 82                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS<br>2                                                 |                                                                                                 | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br>9-11-82                                                                                                          |                     | 7d. HOUR<br>12:12P<br>M                                                             |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                           |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                               |  |                                                                                                  |                                                                                                 | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                          |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                          |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Johns Hopkins Hospital |  |                                                                                                  |                                                                                                 | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                               |                     | 12b. KIND OF BUSINESS OR INDUSTRY                                                   |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                  |  | 13b. COUNTY                                                                                                                       |  | 13c. CITY OR TOWN<br>Baltimore                                                                   |                                                                                                 | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                |                     | 13e. STREET ADDRESS<br>1214 Ensor Street                                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Larry /Venable                                                                                                                                                                                                                                                                                                                                                                                           |  |                  |  |                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Savaughn Young                                     |                                                                                                 |                                                                                                                                                             |                     |                                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                        |  |                  |  | 16b. SOCIAL SECURITY NO.<br>N/A                                                                                                   |  | 17. INFORMANT ADDRESS<br>Savaughn Young 1214 Ensor Street                                        |                                                                                                 |                                                                                                                                                             |                     |                                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sudden infant death syndrome</u><br>7980<br>Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> .<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                                                              |  |                  |  |                                                                                                                                   |  |                                                                                                  |                                                                                                 |                                                                                                                                                             |                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                             |  |                  |  |                                                                                                                                   |  |                                                                                                  |                                                                                                 |                                                                                                                                                             |                     |                                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                 |  |                                                                                                  |                                                                                                 |                                                                                                                                                             |                     | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                             |  |                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                    |                                                                                                 |                                                                                                                                                             |                     |                                                                                     |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                          |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                       |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                   |                                                                                                 |                                                                                                                                                             |                     |                                                                                     |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |                                                                                                                                   |  |                                                                                                  |                                                                                                 |                                                                                                                                                             |                     |                                                                                     |  |
| ACTUAL SIGNATURE <u>Margarita A. Korell</u>                                                                                                                                                                                                                                                                                                                                                                                                     |  |                  |  |                                                                                                                                   |  | TITLE (SPECIFY)<br>M.D. Assistant                                                                |                                                                                                 |                                                                                                                                                             | DATE SIGNED 9-12-82 |                                                                                     |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Margarita A. Korell, M.D.                                                                                                                                                                                                                                                                                                                                                                                    |  |                  |  |                                                                                                                                   |  | ADDRESS<br>111 Penn Street                                                                       |                                                                                                 |                                                                                                                                                             |                     |                                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                             |  |                  |  | 23b. DATE<br>9/16/82                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Eastview Mem. Pk.                                          |                                                                                                 | 23d. LOCATION CITY OR TOWN<br>Baltimore                                                                                                                     |                     | COUNTY STATE<br>Md.                                                                 |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm. C. March F/H 1101 E. North avenue                                                                                                                                                                                                                                                                                                                                                                              |  |                  |  |                                                                                                                                   |  | 25a. DATE REC'D. BY REGISTRAR (P.S.) REGISTRAR'S SIGNATURE<br>SEP 17 1982 <u>John J. Caslick</u> |                                                                                                 |                                                                                                                                                             |                     |                                                                                     |  |

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UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D. C. 20250



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/transfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                        |                                                       |                                                                                                                                                             |                            |                                                                                         |  |                                                                                                                               |  |                                                                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-----------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CHARLES VINCK</b>                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                        | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 10 82</b> |                                                                                                                                                             | 2b. HOUR<br><b>8:10 PM</b> |                                                                                         |  |                                                                                                                               |  |                                                                                                 |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br><b>WHITE</b>                                                                                                                |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>05 17 04</b>                                                                                                       |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.                                       |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                     |  | IF UNDER 24 HRS.                                                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                          |                                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                       |  |                                                                                                                               |  |                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |                                                       |                                                                                                                                                             |                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>STEEL WORKER</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. STEEL</b>                                                                        |  |                                                                                                 |  |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                        |                                                       |                                                                                                                                                             |                            | 13b. COUNTY<br><b>BALTIMORE</b>                                                         |  | 13c. CITY OR TOWN<br><b>ARBUTUS</b>                                                                                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>NESTOR VINCK</b>                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                        |                                                       |                                                                                                                                                             |                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SYLVIA PAQUET</b>                   |  |                                                                                                                               |  |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                                                                                                                                                                                                                                                                                  |  |                                                                                                                                        |                                                       |                                                                                                                                                             |                            | 16b. SOCIAL SECURITY NO.<br><b>169-05-5414</b>                                          |  | 17. INFORMANT<br>ADDRESS<br><b>WILLIAM G. VINCK 635 S. WICKHAM ROAD 21229</b>                                                 |  |                                                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic obstructive Pulmonary Disease, Congestive</b><br><b>4960</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Heart failure, Sepsis,</b><br>(b) <b>G.I. Bleeding, Bilateral Pneumonia, &amp;</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Pneumothorax.</b><br>(c) |  |                                                                                                                                        |                                                       |                                                                                                                                                             |                            |                                                                                         |  |                                                                                                                               |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a                                                                                                                                                                                                                                                              |  |                                                                                                                                        |                                                       |                                                                                                                                                             |                            |                                                                                         |  |                                                                                                                               |  |                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |                                                       |                                                                                                                                                             |                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                      |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                            |                                                                                         |  |                                                                                                                               |  |                                                                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                 |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                            |                                                                                         |  |                                                                                                                               |  |                                                                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-6-1982</b> to <b>9-10-1982</b> , that (I) (we) last saw the deceased alive on <b>before 8:10 PM 9-10-1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                               |  |                                                                                                                                        |                                                       |                                                                                                                                                             |                            |                                                                                         |  |                                                                                                                               |  |                                                                                                 |  |
| 22b. SIGNATURE<br><b>Kaushalendra K. Singh</b>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                        |                                                       | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                            |                                                                                         |  | 22c. DATE SIGNED<br><b>9/10/82</b>                                                                                            |  |                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KAUSHALENDRAK. SINGH</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                        |                                                       | 22e. ADDRESS<br><b>ST. AGNES HOSPITAL</b>                                                                                                                   |                            |                                                                                         |  |                                                                                                                               |  |                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br><b>09-14-82</b>                                                                                                           |                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LAKE VIEW ME. PARK</b>                                                                                             |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>SYKESVILLE CARROLL MARYLAND</b>        |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 14 1982</b>                                                                           |  |                                                                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229</b>                                                                                                                                                                                                                                                                                              |  |                                                                                                                                        |                                                       | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conick</b>                                                                                                         |                            |                                                                                         |  |                                                                                                                               |  |                                                                                                 |  |

MEDICAL CERTIFICATION

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WASHINGTON, D. C.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is signed, injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                      |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                |                                                                                |                                                                                                 |                                                                               |                                                                                                                                       | 8 2 2 3 5 7 4<br>REG. NO.                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                             | FIRST MIDDLE LAST<br>LENA. Lee VIOLI                                   |                                                                                                                                                             |                                                | 2a. DATE OF DEATH MONTH DAY YEAR<br>09/19/1982                                 |                                                                                                 |                                                                               | 2b. HOUR<br>9.05 P.M.                                                                                                                 |                                                      |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br>White                                                                                                                            |                                                                        | 5. DATE OF BIRTH MONTH DAY YEAR<br>Jan. 24 1904                                                                                                             |                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.                                     |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS                                                |                                                                                                                                       | IF UNDER 24 HRS<br>HOURS MIN.                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                      |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                     |                                                                                                 |                                                                               |                                                                                                                                       |                                                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>North Charles General Hospital |                                                                        |                                                                                                                                                             |                                                |                                                                                |                                                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |                                                                                                                                       | 12b. KIND OF BUSINESS OR INDUSTRY                    |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                                                                                    |  |                                                                                                                                             | 13b. CITY<br>Baltimore                                                 |                                                                                                                                                             | 13c. CITY OR TOWN<br>Parkville                 |                                                                                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                               | 13e. STREET ADDRESS<br>9200 Avondale Ave.                                                                                             |                                                      |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Morris C. Hoopes                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                             | 15. MOTHER'S MAIDEN NAME MIDDLE<br>Lillie Deitzel                      |                                                                                                                                                             |                                                |                                                                                |                                                                                                 |                                                                               |                                                                                                                                       |                                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-03-7280                                                                      |                                                                        | 17. INFORMANT ADDRESS<br>Earl J. Hoopws, Jr. 9200 Avondale Ave.                                                                                             |                                                |                                                                                |                                                                                                 |                                                                               |                                                                                                                                       |                                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 5850 POSSIBLE SEPSIS<br>DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC RENAL FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                |                                                                                |                                                                                                 |                                                                               |                                                                                                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>DAYS |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                       |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                |                                                                                |                                                                                                 |                                                                               |                                                                                                                                       |                                                      |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                       |  |                                                                                                                                             | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                |                                                                                                                                                             |                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                 |                                                                               |                                                                                                                                       |                                                      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                   |  |                                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                                                                                                 |                                                                               |                                                                                                                                       |                                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 09/18/1982 to 09/19/1982, that (I) (we) lost saw the deceased alive on 09/19/1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                            |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                |                                                                                |                                                                                                 |                                                                               |                                                                                                                                       |                                                      |  |
| 22b. SIGNATURE<br>D.R. Anger MD                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                | DEGREE<br>MD                                                                   |                                                                                                 |                                                                               | 22c. DATE SIGNED<br>9/19/82                                                                                                           |                                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ANJARIA MD                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                | 22e. ADDRESS<br>NORTH CHARLES GEN hospital<br>BALTIMORE, MD 21218              |                                                                                                 |                                                                               |                                                                                                                                       |                                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                             | 23b. DATE<br>Sept. 22, 1982                                            |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn |                                                                                |                                                                                                 | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                 |                                                                                                                                       |                                                      |  |
| 24. FUNERAL DIRECTOR NAME<br>Leonard J. Ruck, Inc. Baltimore, Maryland                                                                                                                                                                                                                                                                                    |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                | 25a. DATE REC'D. BY REGISTRAR<br>SEP 20 1982                                   |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br>J. R. Ruck                                      |                                                                                                                                       |                                                      |  |

• [cont.](#)

Figure 1

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Dr. J. Thompson, Jr., 2000 17th St., N.W., Wash., D.C.

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by the following:

LEONARD J. BLOOM, Inc., Baltimore, Md.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 5 7 5  
REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                             |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                             |  |
|-------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                         |  | FIRST MIDDLE LAST<br>MICHAEL VLACH                                                                                                 |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>September 19, 1982                                                                                                      |  | 2b. HOUR<br>12:10AM                                         |  |
| 3. SEX<br>Male                                              |  | 4. RACE<br>White                                                                                                                   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Dec. 21, 1892                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>89 YRS.                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Czechoslovakia |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                             |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD. |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Edgewood Nursing Home |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Plumber                                                                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Plumbing               |  |
| 13a. STATE<br>Maryland                                      |  | 13b. CITY OR TOWN<br>Baltimore                                                                                                     |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |  | 13d. STREET ADDRESS<br>7912 Dalesford Road                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jan Vlach         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Caroline                                                                          |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                                      |  |                                                             |  |
| 16b. SOCIAL SECURITY NO.<br>217-09-5531                     |  | 17. INFORMANT ADDRESS<br>Louis O. Vlach 7912 Dalesford Rd. 21234                                                                   |  |                                                                                                                                                             |  |                                                             |  |

|                                                                                                                                                                                                                                                                                                                                     |  |                                                                  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC Arrest.</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>ASCVD.</b><br>(c) <b>GENERAL ARTERIOSCLEROSIS.</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 MINUTES</b> |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **NO**

|                                                                                                                                                                                                                                                                                                                            |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/30/82</b> to <b>9/19/82</b> , that (I) (we) last saw the deceased alive on <b>9-19-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did not) see the body after death. |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Anthony F. Carozza MD.</b>                                                                                                                                                                                                                                                                            |  | DEGREE<br><b>MD.</b>                                                   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>9-20-82</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Anthony F. Carozza</b>                                                                                                                                                                                                                                                         |  | 22e. ADDRESS                                                           |  |                                                                                                                                            |  |                                                                                                                            |  |

|                                                        |  |                                  |  |                                                          |  |                                                                       |  |
|--------------------------------------------------------|--|----------------------------------|--|----------------------------------------------------------|--|-----------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial |  | 23b. DATE<br>Sept. 22, '82       |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Mem. Park |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co., Maryland |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>William E. Johnson     |  | ADDRESS<br>8521 Loch Raven Blvd. |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 20 1982             |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carroll</b>                  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Handwritten notes and stamps at the top of the page, including a date stamp that appears to read "JAN 19 1963".

Handwritten notes in the middle section, including the phrase "General Business" and other illegible scribbles.

Handwritten notes and stamps in the bottom section, including a date stamp that appears to read "JAN 19 1963" and a large, stylized signature or stamp.

Vertical text on the right margin, possibly a page number or reference code, including the word "COPY" and the number "100".



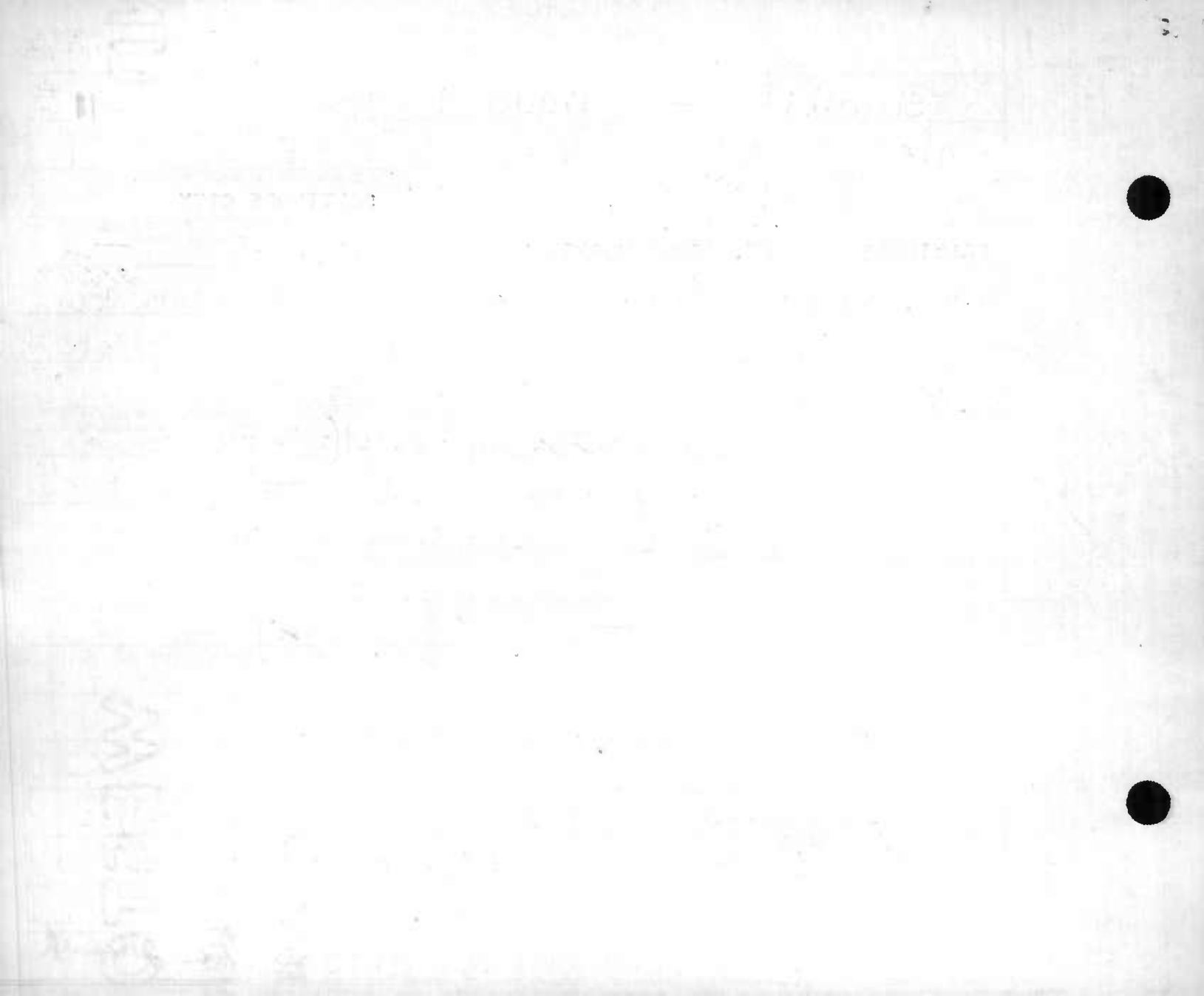
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                           |  |                                                                                                        |  | 8 2 2 3 5 11 24 46<br>REG. NO.                                                                                                                           |  |                                                                                                                         |  |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                                         |  |                                                                                                                         |  | 2b. HOUR                                     |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST                                                                                                                                                                                                                                                             |  |                                                                                                        |  | September 3, 1982                                                                                                                                        |  |                                                                                                                         |  | 11 AM                                        |
| 3. SEX                                                                                                                                                                                                                                                                                                         |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                         |  | 7. IF UNDER 1 YEAR MONTHS DAYS               |
| male                                                                                                                                                                                                                                                                                                           |  | Negro                                                                                                  |  | 7-13-74                                                                                                                                                  |  | 8 YRS                                                                                                                   |  | IF UNDER 24 HRS HOURS MIN.                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OR WHAT COUNTRY?                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                    |  |                                              |
| Balto., MD                                                                                                                                                                                                                                                                                                     |  | United States                                                                                          |  |                                                                                                                                                          |  | BALTIMORE CITY MD.                                                                                                      |  |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |  |                                              |
| BALTIMORE                                                                                                                                                                                                                                                                                                      |  | ST. AGNES HOSPITAL                                                                                     |  | Student                                                                                                                                                  |  |                                                                                                                         |  |                                              |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. CITY OR TOWN                                                                                                                                                                                      |  |                                                                                                        |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  | 13d. STREET ADDRESS                                                                                                     |  |                                              |
| Maryland Baltimore (Baltimore)                                                                                                                                                                                                                                                                                 |  |                                                                                                        |  |                                                                                                                                                          |  | 21207 41 Flaxton Court                                                                                                  |  |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                            |  |                                                                                                        |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                                                                               |  |                                                                                                                         |  |                                              |
| Rufus Norris Waddell                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  | Constance Marshall                                                                                                                                       |  |                                                                                                                         |  |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                              |  |                                                                                                        |  | 16b. SOCIAL SECURITY NO.                                                                                                                                 |  | 17. INFORMANT ADDRESS                                                                                                   |  |                                              |
| NO                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                          |  | Rufus Waddell 21207 Constance Waddell 41 Flaxton Court                                                                  |  |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest (2<sup>nd</sup> to cessation of resp. support)</u> 4939                                                                                                             |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe hypoxic episode at home</u>                                                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                         |  | 36 hours                                     |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe chronic Asthma -&gt; Acute Attack</u>                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                         |  | 36 hours                                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                            |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                         |  |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                             |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                           |  |                                                                                                                         |  |                                              |
|                                                                                                                                                                                                                                                                                                                |  | P.M. 19                                                                                                |  |                                                                                                                                                          |  |                                                                                                                         |  |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                         |  |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/2/82, 19 82, to 9/3, 19 82, that (I) (we) lost the deceased alive on 9/3, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                         |  |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |  | DEGREE                                                                                                                                                   |  |                                                                                                                         |  | 22c. DATE SIGNED                             |
| Jody Lanard                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  | M.D.                                                                                                                                                     |  |                                                                                                                         |  | 9/3/82                                       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                          |  |                                                                                                        |  | 22e. ADDRESS                                                                                                                                             |  |                                                                                                                         |  |                                              |
| JODY LANARD                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  | St. Agnes Hospital, Catonsville, MD                                                                                                                      |  |                                                                                                                         |  |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                      |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                                                 |  |                                              |
| BURIAL                                                                                                                                                                                                                                                                                                         |  | 09/07/82                                                                                               |  | CEDAR HILL CEM.                                                                                                                                          |  | BALTIMORE MARYLAND                                                                                                      |  |                                              |
| 24. FUNERAL DIRECTOR NAME ADDRESS                                                                                                                                                                                                                                                                              |  |                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |  | 25b. REGISTRAR'S SIGNATURE                                                                                              |  |                                              |
| MARSHALL W. JONES, JR./4101 EDMONDSON AVE                                                                                                                                                                                                                                                                      |  |                                                                                                        |  | SEP 10 1982                                                                                                                                              |  | John J. Jones                                                                                                           |  |                                              |





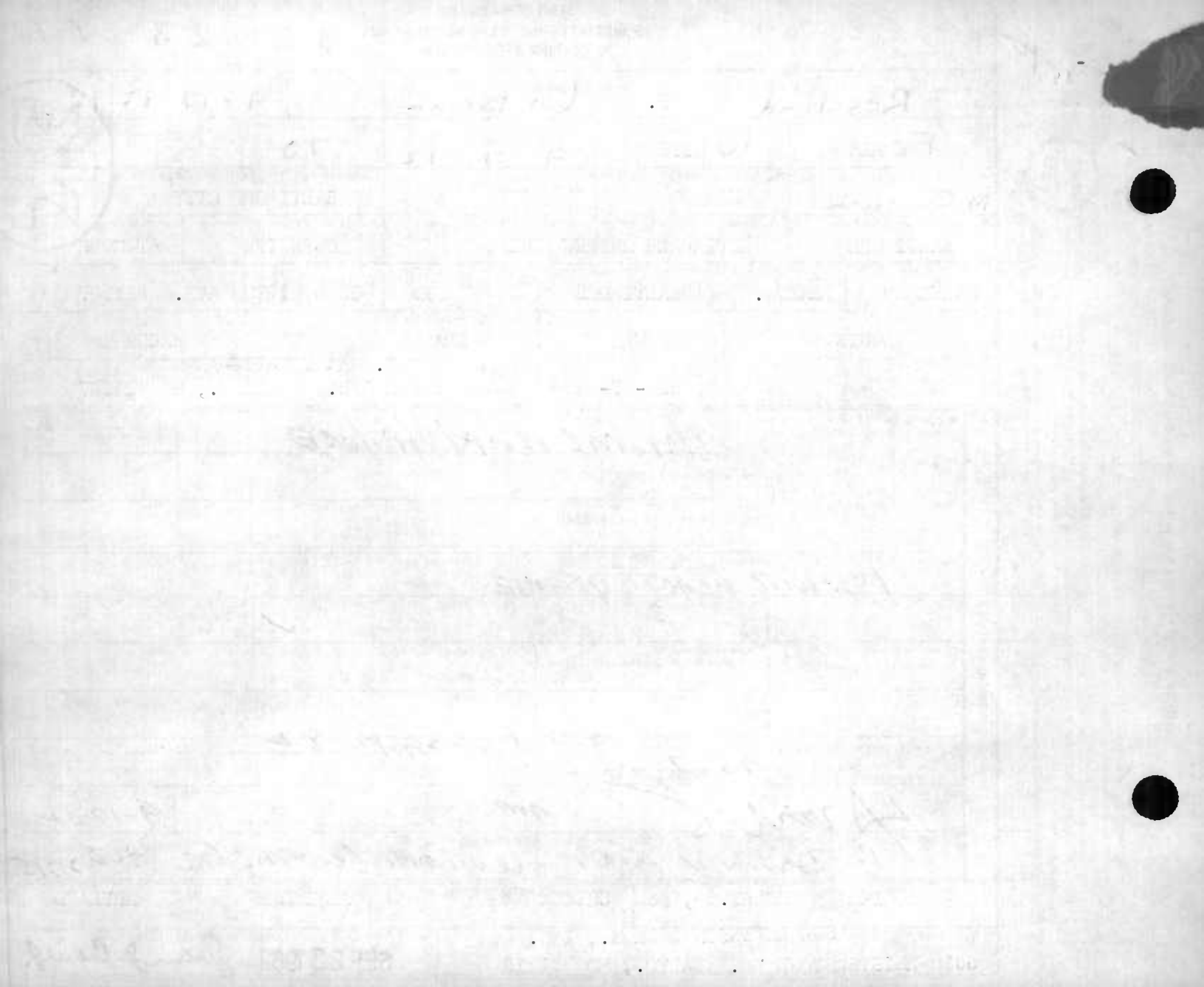
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the cause of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                           |                                                                                        |                                   |                                                                                                                                 |                                                     | 82 23577<br>REG. NO.                                               |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------------------------------------|-----------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|--------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Rosalind F. Waitsman</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                           | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9-17-82</b>                                  |                                   |                                                                                                                                 | 2b. HOUR<br><b>1:15 PM</b>                          |                                                                    |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>WHITE</b>                                                                                                                   |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9-7-12</b>                                                                                                         |                                                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.                                      |                                   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>15</b> MONTHS <b>15</b> DAYS                                                            |                                                     | 8. IF UNDER 24 HRS<br>HOURS MIN.<br><b>15</b> HOURS <b>15</b> MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. Carolina</b>                                                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                      |                                   |                                                                                                                                 |                                                     |                                                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LEVINDALE HEBREW HOME</b> |                                                                        |                                                                                                                                                             |                                                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>   |                                   |                                                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b> |                                                                    |  |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                          |  | 13b. CITY OR TOWN<br><b>BALTO.</b>                                                                                                        |                                                                        | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |                                                           | 13d. STREET ADDRESS<br><b>8060 MILTON AVE. #21207</b>                                  |                                   |                                                                                                                                 |                                                     |                                                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LOUIS SHERMAN</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                           |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>IDA BAKER</b>                                                                                           |                                                           |                                                                                        |                                   |                                                                                                                                 |                                                     |                                                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                           |                                                                        | 16b. SOCIAL SECURITY NO.<br><b>216-07-8284</b>                                                                                                              |                                                           | 17. INFORMANT<br><b>MR. HARRY WAITSMAN</b><br><b>8060 MILTON AVE. BALTO., MD 21207</b> |                                   |                                                                                                                                 |                                                     |                                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic renal failure</b><br><b>5850</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                           |                                                                                        |                                   |                                                                                                                                 |                                                     |                                                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Chronic heart disease</b>                                                                                                                                                                                                                                                   |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                           |                                                                                        |                                   |                                                                                                                                 |                                                     |                                                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                           | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |                                                     |                                                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                               |  |                                                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |                                                                                                                                                             |                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)         |                                   |                                                                                                                                 |                                                     |                                                                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                            |  |                                                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                           | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                      |                                   |                                                                                                                                 |                                                     |                                                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9-9-82</b> to <b>9-17-82</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>9-17-82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                               |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                           |                                                                                        |                                   |                                                                                                                                 |                                                     |                                                                    |  |
| 22b. SIGNATURE<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                           | DEGREE<br><b>MD</b>                                                                    |                                   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                     | 22c. DATE SIGNED<br><b>9-17-82</b>                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B. ZAWADZKI, M.D.</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                           | 22e. ADDRESS<br><b>Levinson &amp; Bros. Co. BALTO, MD</b>                              |                                   |                                                                                                                                 |                                                     |                                                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                           | 23b. DATE<br><b>SEPT. 20, 1982</b>                                     |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CHIZUK AMONO</b> |                                                                                        | 23d. LOCATION<br><b>BALTIMORE</b> |                                                                                                                                 | COUNTY <b>MARYLAND</b>                              |                                                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>                                                                                                                                                                                                                                                                                         |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                           | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 23 1982</b>                                    |                                   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                                |                                                     |                                                                    |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                                                                            |                                                                |                                                                                                 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                             |  | REG. NO.                                                                                                                               |  |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                                                                            |                                                                |                                                                                                 |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HOWARD G. WALKER</b>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                        |  |                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 3 1982</b>                                                                                               |  |                                                                                                                            | 2b. HOUR<br><b>9:45 PM</b>                                     |                                                                                                 |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br><b>White</b>                                                                                                                |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 28 14</b>                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.                                                                                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>                                                                               |                                                                | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b>                                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                          |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                                                                                     |  |                                                                                                                            |                                                                |                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b>                                                                     |  |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Atlantic Richfield</b> |                                                                                                 |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                        |  |                                                                                                                                                             |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                      |  | 13c. CITY OR TOWN<br><b>Catonsville</b>                                                                                    |                                                                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Willard Walker</b>                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                        |  |                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rebecca Jones</b>                                                                                |  |                                                                                                                            |                                                                |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br><b>215-09-4144</b>                                                                                                              |  | 17. INFORMANT<br>ADDRESS<br><b>Claire R. Walker 51 Dungarrie Road 21228</b>                                                                          |  |                                                                                                                            |                                                                |                                                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>5698</b> IMMEDIATE CAUSE (a) <b>Hypotension Bradycardia</b><br>DUE TO, OR AS A CONSEQUENCE OF, <b>Cardiac arrest</b><br>(b) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF, <b>Perforation of descending colon.</b><br>(c) <b>Ruptured aortic aneurysm repaired 8/25/82</b>                       |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                                                                            |                                                                |                                                                                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Ruptured aortic aneurysm repaired 8/25/82</b>                                                                                                                                                                                                                            |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                                                                            |                                                                |                                                                                                 |  |
| 19a. DATE OF OPERATION<br><b>9.3.82</b>                                                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>gangrenous bowel</b>                                                            |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                 |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                |                                                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)                                                                              |  |                                                                                                                                                      |  |                                                                                                                            |                                                                |                                                                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                                                      |  |                                                                                                                            |                                                                |                                                                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/21/82</b> to <b>9/3/82</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>9/3/82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did (did not) view the body after death. |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                                                                            |                                                                |                                                                                                 |  |
| 22b. SIGNATURE<br><b>S. Chalabi</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                        |  |                                                                                                                                                             |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED                                                                                                           |                                                                |                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SAMIM CHALABI MD</b>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                        |  |                                                                                                                                                             |  | 22e. ADDRESS                                                                                                                                         |  |                                                                                                                            |                                                                |                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br><b>9/7/82</b>                                                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lakeview Mem. Park</b>                                                                                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sykesville Carroll Md.</b>                                                                          |  |                                                                                                                            |                                                                |                                                                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc.</b>                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                        |  |                                                                                                                                                             |  | 24b. ADDRESS<br><b>4107 Wilkens Ave.</b>                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 7 1982</b>                                                                         |                                                                | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canine</b>                                             |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                            |  |                                                                                                                       |  |                                                                                                                                                             |  |                                                                                   |  |                                                                                                                         |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                          |  | 8 2 2 3 5 7 9                                                                                                         |  | REG. NO.                                                                                                                                                    |  |                                                                                   |  |                                                                                                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>JACQUELINE V WALKER                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                       |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>SEPTEMBER 5 1982                                                                                                        |  | 2b. HOUR<br>5:00 pm                                                               |  |                                                                                                                         |  |
| 3. SEX<br>Fe                                                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br>Black                                                                                                      |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>6 28 1909                                                                                                                |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>73                                        |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA.                                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>City - BALTO MD.                          |  |                                                                                                                         |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Home |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                                                                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home                                         |  |                                                                                                                         |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>Md. BALTO TURNERS                                                                                                                                                                                                                                      |  |                                                                                                                       |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                |  | 13e. STREET ADDRESS<br>120 Sollores Pt.                                           |  |                                                                                                                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Charles Flowers                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                       |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Sarah Jane Flowers                                                                                            |  |                                                                                   |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.                                                                                              |  | 17. INFORMANT<br>JAMES V. WALKER                                                                                                                            |  | ADDRESS<br>255 MARTIN LUTHER KING                                                 |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST<br>1539<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) CARCINOMA COLON WITH WIDESPREAD<br>(c) METASTASES<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |                                                                                                                       |  |                                                                                                                                                             |  |                                                                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                                            |  |                                                                                                                       |  |                                                                                                                                                             |  |                                                                                   |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>CARCINOMA COLON                                                   |  |                                                                                                                                                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                   |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                   |  |                                                                                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from AUGUST 23 19 82, to SEPTEMBER 5 19 82, that (I) (we) last saw the deceased alive on SEPTEMBER 5 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                              |  |                                                                                                                       |  |                                                                                                                                                             |  |                                                                                   |  |                                                                                                                         |  |
| 22b. SIGNATURE<br>George Thomas                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                       |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  |                                                                                   |  | 22c. DATE SIGNED                                                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GEORGE THOMAS MD                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                       |  | 22e. ADDRESS<br>100 N. BROADWAY BALTIMORE, MD; 21231                                                                                                        |  |                                                                                   |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                             |  | 23b. DATE<br>9-10-82                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ARbutus                                                                                                               |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTO Md.                              |  |                                                                                                                         |  |
| 24. FUNERAL DIRECTOR NAME<br>James Martin                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                       |  | ADDRESS<br>7 H-1701 LAURENS                                                                                                                                 |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 8 1982                                       |  |                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                       |  |                                                                                                                                                             |  | REGISTRAR'S SIGNATURE<br>John J. Carver                                           |  |                                                                                                                         |  |



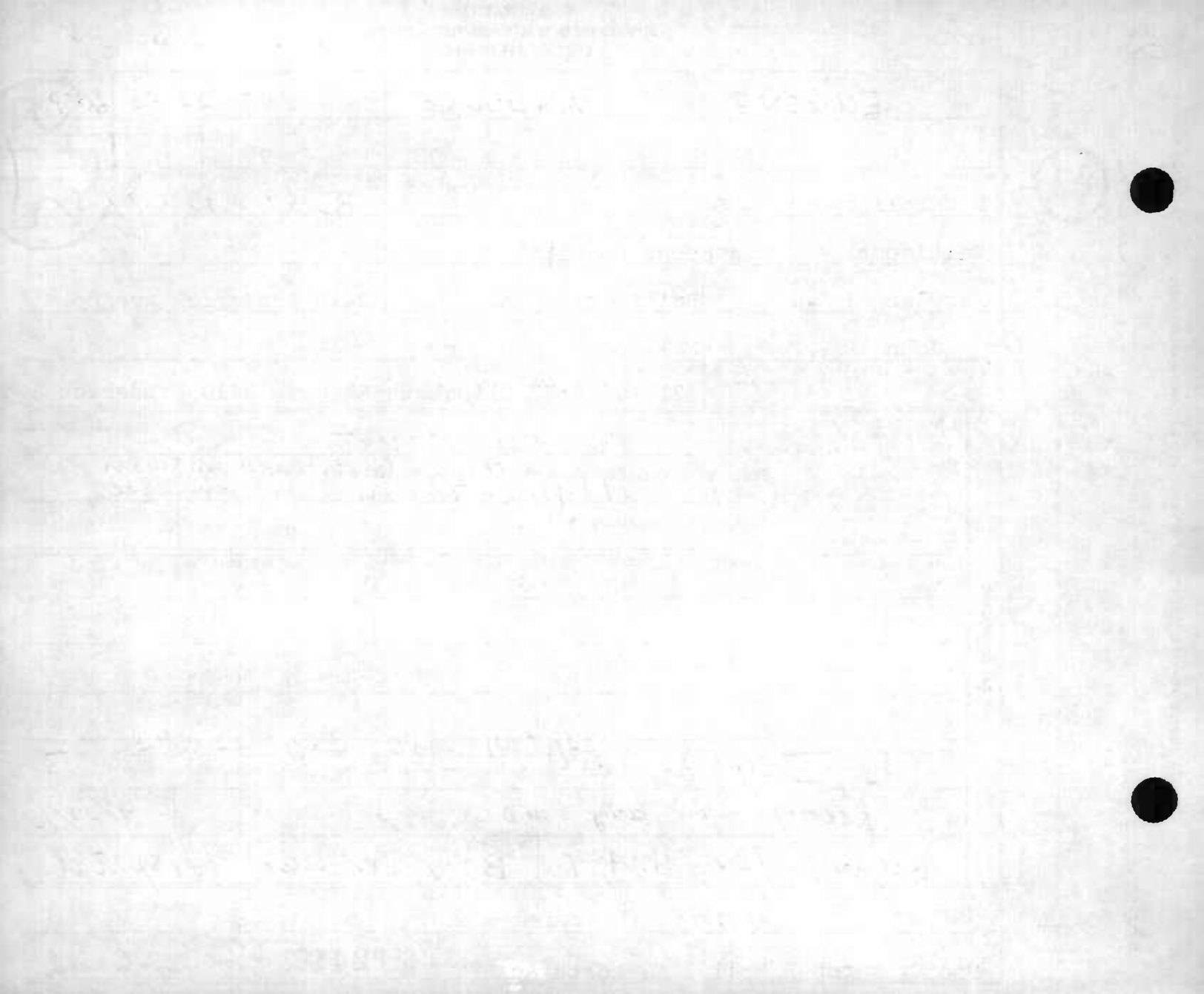


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                     |  | REG. NO. 8 2 2 3 5 8 0                                                                                 |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                           |  | FIRST                                                                                                  |  | MIDDLE                                                                                                                                                   |  | LAST                                                                                                                                       |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                        |  | 2b. HOUR                                     |  |
| EUGENE                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  |                                                                                                                                                          |  | WALLACE                                                                                                                                    |  | 09 22 82                                                                                                                |  | 6:30P M                                      |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                                            |  | IF UNDER 1 YEAR MONTHS DAYS                                                                                             |  | IF UNDER 24 HRS HOURS MIN.                   |  |
| Male                                                                                                                                                                                                                                                                                                                                                                       |  | Black                                                                                                  |  | 1 8 05                                                                                                                                                   |  | 77 YRS.                                                                                                                                    |  |                                                                                                                         |  |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                       |  |                                                                                                                         |  |                                              |  |
| N. Carolina                                                                                                                                                                                                                                                                                                                                                                |  | USA                                                                                                    |  |                                                                                                                                                          |  | Baltimore city MD.                                                                                                                         |  |                                                                                                                         |  |                                              |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                  |  | Bon Secur Hospital                                                                                     |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                                                                                                                                                                                                                                              |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                      |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                 |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                               |  | 13e. STREET ADDRESS                                                                                                     |  |                                              |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  | Baltimore                                                                                                                                                |  |                                                                                                                                            |  | 2410 Frederick Avenue                                                                                                   |  |                                              |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                                                                               |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| John Wallace                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  | Mary                                                                                                                                                     |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.                                                                               |  | 17. INFORMANT                                                                                                                                            |  | ADDRESS                                                                                                                                    |  |                                                                                                                         |  |                                              |  |
| No                                                                                                                                                                                                                                                                                                                                                                         |  | 714-09-6577                                                                                            |  | Elizabeth Shannon                                                                                                                                        |  | 2410 Frederick Ave                                                                                                                         |  |                                                                                                                         |  |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF <u>arteriosclerotic cardiovascular disease</u>                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>Hypertension</u>                                                                                                                                                                                                                                                          |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension</u>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                                                                                            |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  |                                                                                                                                                          |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                          |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.                                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                            |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Sept 01</u> , 19 <u>80</u> , to <u>Sept 22</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>Sept 22</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                             |  | DEGREE                                                                                                 |  |                                                                                                                                                          |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED                                                                                                        |  |                                              |  |
| Kuang-Yen Huang                                                                                                                                                                                                                                                                                                                                                            |  | M.D.                                                                                                   |  |                                                                                                                                                          |  |                                                                                                                                            |  | 9/23/82                                                                                                                 |  |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                      |  | 22e. ADDRESS                                                                                           |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| KUANG-YEN HUANG                                                                                                                                                                                                                                                                                                                                                            |  | BON Securus Hospital                                                                                   |  |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                                                         |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                                                                    |  |                                                                                                                         |  |                                              |  |
| BURIAL                                                                                                                                                                                                                                                                                                                                                                     |  | 9/27/82                                                                                                |  | Eastview mem. Pk.                                                                                                                                        |  | Baltimore Md                                                                                                                               |  |                                                                                                                         |  |                                              |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                  |  | ADDRESS                                                                                                |  |                                                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                              |  | 25b. REGISTRAR'S SIGNATURE                                                                                              |  |                                              |  |
| Wm. C. march F/H 1101 E. North                                                                                                                                                                                                                                                                                                                                             |  | Ave                                                                                                    |  |                                                                                                                                                          |  | SEP 24 1982                                                                                                                                |  | John J. Conish                                                                                                          |  |                                              |  |



1- FOR Item 19 Film 572 10-26-82  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

8 2 2 3 5 8 1

|                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    |                                                     |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                       |                                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LESTER HARRY WALSKY</b>                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                    | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>09-22-82</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>10<sup>22</sup> P.M.</b>                                                         |  |                                                                                                                                       |                                                              |
| 3. SEX<br><b>M ALE</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br><b>WHITE</b>                                                                                                            |                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>07-04-14</b>                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.                                               |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                          |                                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                      |                                                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |                                                                                                                                       |                                                              |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |                                                     |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MARINE ELECTRICIAN</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. COAST</b>                                                                                |                                                              |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                    |                                                     | 13b. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                       |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>4171 LABYRINTH RD. #2125</b>                                                                                |                                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MAX WALSKY</b>                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                    |                                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNA SOLOMON</b>                                                                                        |  |                                                                                                 |  |                                                                                                                                       |                                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                    |                                                     | 16b. SOCIAL SECURITY NO.<br><b>220-07-1743</b>                                                                                                              |  | 17. INFORMANT<br><b>MRS. THELMA WALSKY</b><br><b>4171 LABYRINTH RD. BALTO., MD 21215</b>        |  |                                                                                                                                       |                                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>5355 IMMEDIATE CAUSE (a) GASTROINTESTINAL BLEEDING</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Stress gastritis / Stress ulcer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |                                                                                                                                    |                                                     |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Hours</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Aspiration Pneumonia c Resp insuffr CVA; HPM; Cardiac Arrhythmia.</b>                                                                                                                                                                                        |  |                                                                                                                                    |                                                     |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                       |                                                              |
| 19a. DATE OF OPERATION<br><b>9/3/82</b>                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>feeding jejunostomy</b>                                                     |                                                     |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                                                                  |                                                     | 21c. HOW INJURY OCCURRED (GIVE NATURE OF INJURY IN PART 18, PART 2 OR PART 3)<br><b>Inability to swallow</b>                                                |  |                                                                                                 |  |                                                                                                                                       |                                                              |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                             |                                                     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                                       |                                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March, 1970</b> to <b>September 23, 1982</b> that (I) (we) last saw the deceased alive on <b>Sept. 22, 1982</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                          |  |                                                                                                                                    |                                                     |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                       |                                                              |
| 22b. SIGNATURE<br><b>B. A. Cochran, M.D.</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                    |                                                     | DEGREE<br><b>MD</b>                                                                                                                                         |  |                                                                                                 |  | 22c. DATE SIGNED<br><b>9/22/82</b>                                                                                                    |                                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B. A. Cochran, M.D.</b>                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                    |                                                     | 22e. ADDRESS<br><b>6506 PARK HILL COTTAGE AVE BALTIMORE 21215</b>                                                                                           |  |                                                                                                 |  |                                                                                                                                       |                                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE<br><b>SEPT. 24, 1982</b>                                                                                                 |                                                     | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HEBREW YOUNG MEN</b>                                                                                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>                         |  |                                                                                                                                       |                                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                    |                                                     | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 29 1982</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Cochran</b>                                            |  |                                                                                                                                       |                                                              |
| 6010 REISTERSTOWN RD. BALTO., MD 21215                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                    |                                                     |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                                       |                                                              |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D.C.



OFFICE OF THE  
DIRECTOR

BOX 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

item 13a 17 #G571 9/23/82 ph

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

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| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIAM HENRY WARD, JR.</b> |  |                                                                                                                                           | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9/21/82</b>                 |                                                                                                                                                             | 2b. HOUR<br><b>6:38 AM</b> |                                                                       |  |
| 3 SEX<br><b>Male</b>                                                                       |  | 4. RACE<br><b>White</b>                                                                                                                   |                                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 20 24</b>                                                                                                        |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b><br>YRS. MONTHS DAYS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                             |                                                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b> MD.         |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY OF MD HOSP</b> |                                                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mechanic</b>                                                                         |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Self Employed</b>             |  |
| 13a. STATE<br><b>Maryland</b>                                                              |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                           |                                                                       | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |                            | 13d. STREET ADDRESS<br><b>1243 1242-Glyndon Avenue</b> 21223          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William H. Ward, Sr.</b>                      |  |                                                                                                                                           | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sarah Unknown</b> |                                                                                                                                                             |                            |                                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>          |  | 16b. SOCIAL SECURITY NO.<br><b>217-12-0074</b>                                                                                            |                                                                       | 17. INFORMANT<br><b>Agnes M. Ward</b> ADDRESS<br><b>1243 1242-Glyndon Avenue</b> 21223                                                                      |                            |                                                                       |  |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4100 congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>day</b><br><b>days</b> |  |
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Ventricular tachycardia; pneumonia**

|                                                                                                                                                                                                                                                                                                                                   |  |                                                                        |  |                                                                                                                                                      |  |                                                                                                                            |  |
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| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                 |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                       |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Joseph M. Perilly M.D.</b>                                                                                                                                                                                                                                                                                   |  |                                                                        |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>9/21/82</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOSEPH M. Perilly</b>                                                                                                                                                                                                                                                                 |  |                                                                        |  | 22e. ADDRESS<br><b>University Hospital</b>                                                                                                           |  |                                                                                                                            |  |

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| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>9/24/82</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |  |
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| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.</b> |  | 25. DATE RECEIVED BY REGISTRAR<br><b>SEP 22 1982</b> |  | 26. REGISTRAR'S SIGNATURE<br><b>John J. Canale</b> |  |
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| NAME |  | ADDRESS |  | CITY |  | STATE |  | COUNTRY |  |
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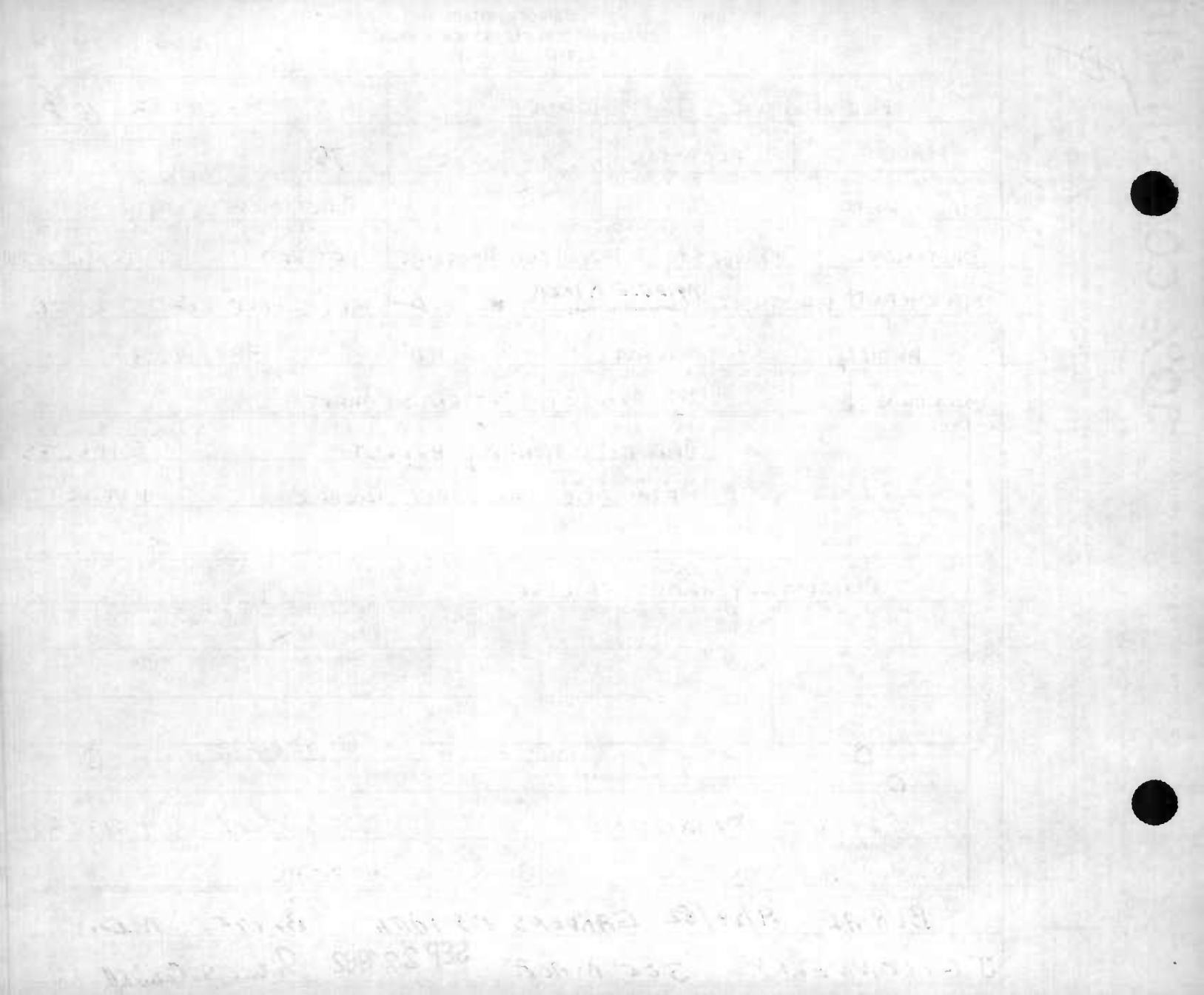
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at the funeral home.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                   |  |                                                                                                                         |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 8 2 2 3 5 8 3                                                                                                                             |  |                                                                                                                                                             |  | REG. NO.                                                                          |  |                                                                                                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>ALEXANDER J. WASEL                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                           |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>9-20-82                                                                                                                 |  |                                                                                   |  | 2b. HOUR MIN.<br>10 15 M                                                                                                |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br>CAUCASIAN                                                                                                                      |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>9-4-12                                                                                                                   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.                                        |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                           |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                    |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                        |  |                                                                                                                         |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIVERSITY OF MARYLAND HOSPITAL |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>WESTERN ELECTRIC                                                                   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                     |  | 13b. CITY OR TOWN<br>BALTIMORE                                                                                                            |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                |  | 13e. STREET ADDRESS<br>1501 SHORE ROAD 21220                                      |  |                                                                                                                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>ANTHONY WASEL                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                           |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ALICE BACKHOUSE                                                                                               |  |                                                                                   |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>UNKNOWN                                                                                                                                                                                                                                                                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.<br>212-07-0837                                                                                                   |  | 17. INFORMANT ADDRESS<br>PATIENT'S CHART                                                                                                                    |  |                                                                                   |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u><br>1579<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC PANCREATIC CANCER</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 MINUTES<br>1 YEAR |  |                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                   |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>CONGESTIVE HEART FAILURE                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                   |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                          |  |                                                                                                                                                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                   |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        |  | 21f. LOCATION STREET                                                                                                                                        |  | CITY OR TOWN                                                                      |  | COUNTY STATE                                                                                                            |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>9-13-82</u> , 19____, to <u>9-20-82</u> , 19____, that (1) (we) last saw the deceased alive on <u>9-20-82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.                                                                                                                     |  |                                                                                                                                           |  |                                                                                                                                                             |  |                                                                                   |  |                                                                                                                         |  |
| 22b. SIGNATURE<br>Lauren A. Schnaper MD                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                           |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |                                                                                   |  | 22c. DATE SIGNED<br>9-20-82                                                                                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LAUREN A. SCHNAPER                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                           |  | 22e. ADDRESS<br>UNIVERSITY HOSPITAL                                                                                                                         |  |                                                                                   |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br>9/24/82                                                                                                                      |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GARDENS OF FAITH                                                                                                      |  | 23d. LOCATION CITY OR TOWN<br>BALTC.                                              |  | COUNTY STATE<br>MD.                                                                                                     |  |
| 24. FUNERAL DIRECTOR NAME<br>J.B. CONNELLY                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                           |  | ADDRESS<br>300 MACE                                                                                                                                         |  | DATE REC'D. BY REGISTRAR<br>SEP 22 1982                                           |  | REGISTRAR'S SIGNATURE<br>John J. Connelly                                                                               |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

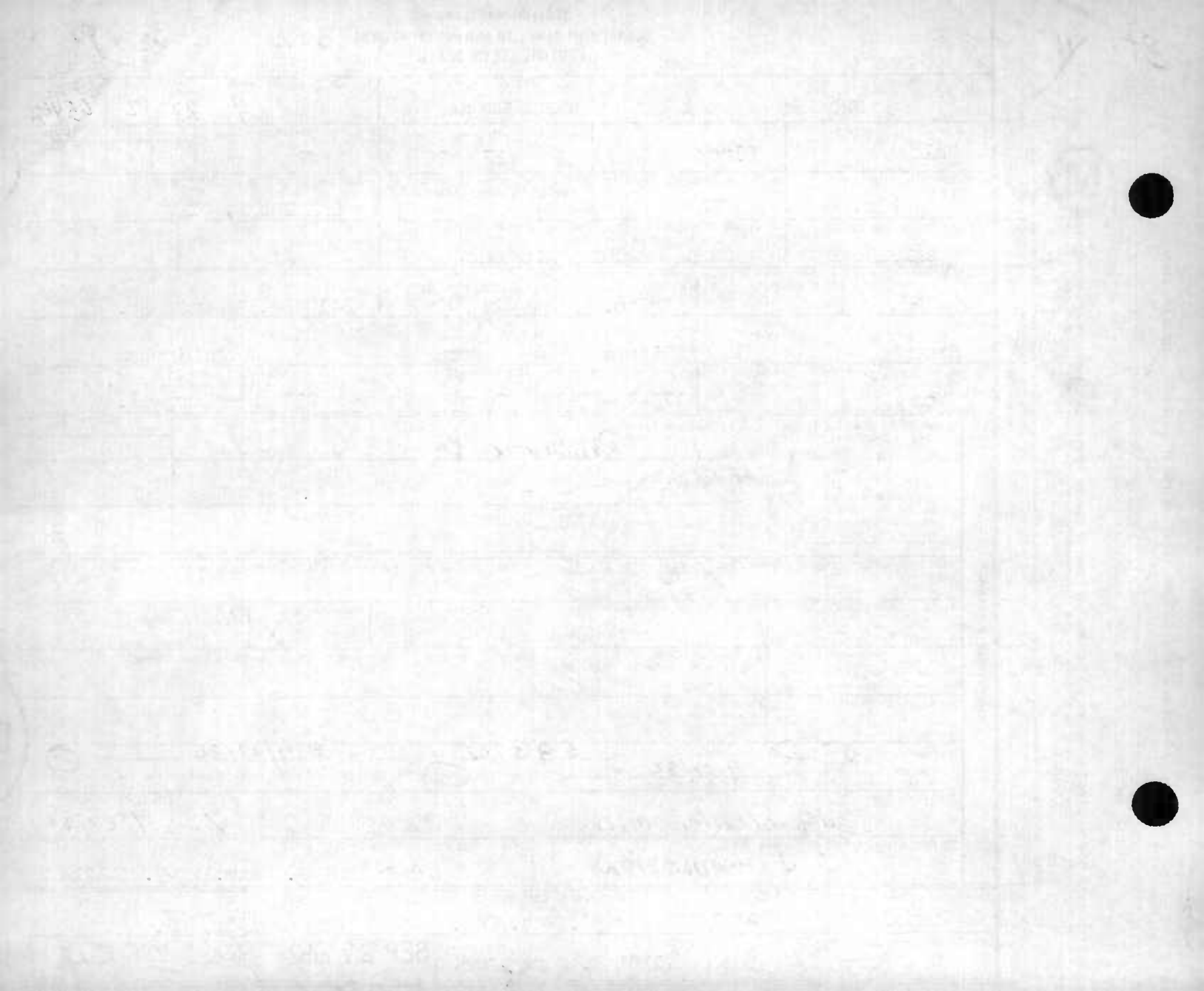
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 5 8 4  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                      |                                                                                                                                                             |                                                                                 |                                                                                                 |                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>THOMAS H. WASHINGTON                                                                                                                                                                                                                                                                                                          |                                                                                                                                      |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9 22 82                                  |                                                                                                 | 2b. HOUR<br>0540 AM                                                                                                        |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                       | 4. RACE<br>Black                                                                                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 17 39                                                                                                               |                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>43 YRS.                                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ala.                                                                                                                                                                                                                                                                                                                    | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE, CITY MD.                                     |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |                                                                                                                            |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                      | 13b. COUNTY                                                                                                                                                 | 13c. CITY OR TOWN<br>Balto.                                                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Williams                                                                                                                                                                                                                                                                                                            |                                                                                                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Cora Washington                                                                                            |                                                                                 |                                                                                                 |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes                                                                                                                                                                                                                                                              |                                                                                                                                      | 16b. SOCIAL SECURITY NO.<br>176-30-1113                                                                                                                     | 17. INFORMANT<br>ADDRESS<br>Cora Robinson Plainfield, N.J.<br>229 Mulenburg Pl. |                                                                                                 |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pancreatic Ca</u><br>1579<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____         |                                                                                                                                      |                                                                                                                                                             |                                                                                 |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____                                                                                                                                                                                                                           |                                                                                                                                      |                                                                                                                                                             |                                                                                 |                                                                                                 |                                                                                                                            |
| 19a. DATE OF OPERATION<br>-                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>-                                                                                                       |                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                             |                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                                                                                                 |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                          |                                                                                                                                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                               |                                                                                                 |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/5/82</u> 19 <u>82</u> , to <u>8/22/82</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>9/22/82</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                                                      |                                                                                                                                                             |                                                                                 |                                                                                                 |                                                                                                                            |
| 22b. SIGNATURE<br><u>J. Huddleston M.D.</u>                                                                                                                                                                                                                                                                                                                          |                                                                                                                                      | DEGREE                                                                                                                                                      |                                                                                 | 22c. DATE SIGNED<br>9/22/82                                                                     |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. HUDDLESTON                                                                                                                                                                                                                                                                                                               |                                                                                                                                      | 22e. ADDRESS<br>UMH 201 E. Univ. PKwy. #21218                                                                                                               |                                                                                 |                                                                                                 |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                               | 23b. DATE<br>9/27/82                                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Vet. Cem.                                                                                                         |                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crownsville, Md.                                  |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H, Inc.                                                                                                                                                                                                                                                                                                                 |                                                                                                                                      | ADDRESS<br>1101 E. North Ave.                                                                                                                               |                                                                                 | 25. DATE RECEIVED BY REGISTRAR (REGISTRAR'S SIGNATURE)<br>SEP 27 1982 <u>John J. Lauer</u>      |                                                                                                                            |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 5 8 5

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                     |                                                                                                                                                             |                                                                                      |                                                                                      |                                                                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>NAOMI D. WATKINS</b>                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                     |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>SEPTEMBER 29, 1982</b>                     |                                                                                      | 2b. HOUR<br><b>6:30 A</b>                                                                       |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4. RACE<br><b>White</b>                                                                                                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>February 22, 1916</b>                                                                                              |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.                                    |                                                                                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |                                                                                                 |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                     |                                                                                                                                                             | 13b. COUNTY                                                                          | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Albert Anft</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                     |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Helen Yeager</b>                 |                                                                                      |                                                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                     | 16b. SOCIAL SECURITY NO<br><b>215-07-1717</b>                                                                                                               |                                                                                      | 17. INFORMANT<br>ADDRESS<br><b>Mr Paul A. Watkins 621 Fairway Dr</b>                 |                                                                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CARCINOMA COLON WITH METASTASIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ANEMIA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                    |                                                                                                                                     |                                                                                                                                                             |                                                                                      |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                     |                                                                                                                                                             |                                                                                      |                                                                                      |                                                                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |                                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |                                                                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/28</b> , 19 <b>82</b> , to <b>9/29</b> , 19 <b>82</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>9/29</b> , 19 <b>82</b> , and that in (my <input checked="" type="checkbox"/> our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did (did not) view the body after death. |                                                                                                                                     |                                                                                                                                                             |                                                                                      |                                                                                      |                                                                                                 |
| 22b. SIGNATURE<br><b>Marked Luther W</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                     | DEGREE                                                                                                                                                      |                                                                                      | 22c. DATE SIGNED<br><b>9/29/82</b>                                                   |                                                                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. LUHAR M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                     | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 N. BROADWAY BALTO. MD. 21231</b>                                                                     |                                                                                      |                                                                                      |                                                                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                     | 23b. DATE<br><b>10/1/82</b>                                                                                                                                 |                                                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem. Park</b>                      |                                                                                                 |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                                                                                    |                                                                                      | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 29 1982</b>                                  |                                                                                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                     |                                                                                                                                                             |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                  |                                                                                                 |

NOTICE

NOTICE



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                         |  |                                                                                                         |  |                                                             |  |                                                                                              |  |                                                                         |  |                                                                                                                                                                                                      |  |
|-----------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                  |  | 2. DATE KNOWN OF DEATH                                                                                  |  | 3. MONTH                                                    |  | 4. DAY                                                                                       |  | 5. YEAR                                                                 |  | 6. HOUR                                                                                                                                                                                              |  |
| 1a. DECEASED NAME (TYPE OR PRINT)                                                                                                       |  | 1b. DATE OF BIRTH                                                                                       |  | 1c. AGE (IN YEARS LAST BIRTHDAY)                            |  | 1d. IF UNDER 1 YR.                                                                           |  | 1e. IF UNDER 24 HRS.                                                    |  | 1f. DATE PRONOUNCED DEAD                                                                                                                                                                             |  |
| Nancy Jo Watson                                                                                                                         |  | Aug. 19 1955                                                                                            |  | 27 YRS.                                                     |  |                                                                                              |  |                                                                         |  | 9-11-82 8:55A                                                                                                                                                                                        |  |
| 3. SEX                                                                                                                                  |  | 4. RACE                                                                                                 |  | 5. DATE OF BIRTH                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                              |  | 7. IF UNDER 1 YR.                                                       |  | 8. IF UNDER 24 HRS.                                                                                                                                                                                  |  |
| FEMALE                                                                                                                                  |  | WHITE                                                                                                   |  | Aug. 19 1955                                                |  | 27 YRS.                                                                                      |  |                                                                         |  |                                                                                                                                                                                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                            |  | 8. MARRIED                                                  |  | 9. NEVER MARRIED                                                                             |  | 10. WIDOWED                                                             |  | 11. DIVORCED                                                                                                                                                                                         |  |
| MINNESOTA                                                                                                                               |  | U. S. A.                                                                                                |  |                                                             |  |                                                                                              |  |                                                                         |  |                                                                                                                                                                                                      |  |
| 12. CITY OR TOWN OF DEATH                                                                                                               |  | 13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 14. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) |  | 15. KIND OF BUSINESS OR INDUSTRY                                                             |  | 16. BALTIMORE CITY OR COUNTY OF DEATH                                   |  | 17. BALTIMORE CITY                                                                                                                                                                                   |  |
| Baltimore                                                                                                                               |  | University Hospital                                                                                     |  | SALES REPRESENTATIVE                                        |  | MD. BARRANGO                                                                                 |  |                                                                         |  |                                                                                                                                                                                                      |  |
| 18. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                          |  | 19. STATE                                                                                               |  | 20. COUNTY                                                  |  | 21. CITY OR TOWN                                                                             |  | 22. INSIDE CITY LIMITS?                                                 |  | 23. STREET ADDRESS                                                                                                                                                                                   |  |
| MARYLAND                                                                                                                                |  | ANNE ARUNDEL                                                                                            |  | SEVERNA PARK                                                |  |                                                                                              |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |  | 180 TAMGLADE                                                                                                                                                                                         |  |
| 24. FATHER'S NAME                                                                                                                       |  | 25. MOTHER'S MAIDEN NAME                                                                                |  | 26. WAS DECEASED EVER IN U.S. ARMED FORCES?                 |  | 27. SOCIAL SECURITY NO.                                                                      |  | 28. INFORMANT                                                           |  | 29. ADDRESS                                                                                                                                                                                          |  |
| BURKE                                                                                                                                   |  | BUNNY                                                                                                   |  | NO                                                          |  | 213706398                                                                                    |  | BURKE P. WATSON                                                         |  | (SAME AS 13)                                                                                                                                                                                         |  |
| 30. PART I DEATH WAS CAUSED BY:                                                                                                         |  | 31. IMMEDIATE CAUSE (a)                                                                                 |  | 32. DUE TO, OR AS A CONSEQUENCE OF                          |  | 33. (b)                                                                                      |  | 34. DUE TO, OR AS A CONSEQUENCE OF                                      |  | 35. (c)                                                                                                                                                                                              |  |
| 8120                                                                                                                                    |  | Transection of aorta                                                                                    |  |                                                             |  |                                                                                              |  |                                                                         |  |                                                                                                                                                                                                      |  |
| 36. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  | 37. DATE OF OPERATION                                                                                   |  | 38. CONDITION FOR WHICH OPERATION WAS PERFORMED?            |  | 39. AUTOPSY?                                                                                 |  | 40. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                                                                                                                                                                                      |  |
| 41. UNDERLYING CAUSE OF DEATH                                                                                                           |  | 42. TIME OF INJURY                                                                                      |  | 43. HOW INJURY OCCURRED                                     |  | 44. INJURY OCCURRED                                                                          |  | 45. PLACE OF INJURY                                                     |  | 46. LOCATION                                                                                                                                                                                         |  |
| X                                                                                                                                       |  | 8:02AM 9-11-82                                                                                          |  | driver of auto which collided with the rear of              |  | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> |  | street                                                                  |  | Belair Rd. 42ft. N. of Baltimore, Maryland                                                                                                                                                           |  |
| 47. 22a I certify that I took charge of the remains described above, held on                                                            |  | 48. Autopsy                                                                                             |  | 49. Inspection                                              |  | 50. Inquiry                                                                                  |  | 51. and in my opinion                                                   |  | 52. death resulted from:                                                                                                                                                                             |  |
| Margarita A. Korell, M.D.                                                                                                               |  | Assistant                                                                                               |  |                                                             |  |                                                                                              |  |                                                                         |  | Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |
| 53. ACTUAL SIGNATURE                                                                                                                    |  | 54. EXAMINER'S NAME (TYPE OR PRINT)                                                                     |  | 55. ADDRESS                                                 |  | 56. DATE REC'D. BY REGISTRAR                                                                 |  | 57. REGISTRAR'S SIGNATURE                                               |  | 58. DATE                                                                                                                                                                                             |  |
|                                                                                                                                         |  | Margarita A. Korell, M.D.                                                                               |  | 111 Penn Street                                             |  | SEP 16 1982                                                                                  |  | John J. Connel                                                          |  | 9-11-82                                                                                                                                                                                              |  |
| 59. 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                           |  | 60. DATE                                                                                                |  | 61. NAME OF CEMETERY OR CREMATORY                           |  | 62. LOCATION                                                                                 |  | 63. COUNTY                                                              |  | 64. STATE                                                                                                                                                                                            |  |
| BURIAL                                                                                                                                  |  | SEPT. 14, 1982                                                                                          |  | GLEN HAVEN CEMETERY                                         |  | GLEN BURNIE                                                                                  |  | ANNE ARUNDEL                                                            |  | MD.                                                                                                                                                                                                  |  |
| 65. 24. FUNERAL DIRECTOR                                                                                                                |  | 66. ADDRESS                                                                                             |  | 67. DATE REC'D. BY REGISTRAR                                |  | 68. REGISTRAR'S SIGNATURE                                                                    |  | 69. DATE                                                                |  | 70. REGISTRAR'S SIGNATURE                                                                                                                                                                            |  |
| ROBERT S. BARRANGO                                                                                                                      |  | 501 RITCHIE HWY. SEVERNA PARK, MD.                                                                      |  | SEP 16 1982                                                 |  | John J. Connel                                                                               |  |                                                                         |  |                                                                                                                                                                                                      |  |



RECEIVED  
JAN 10 1964  
U.S. AIR FORCE  
HONOLULU, HAWAII



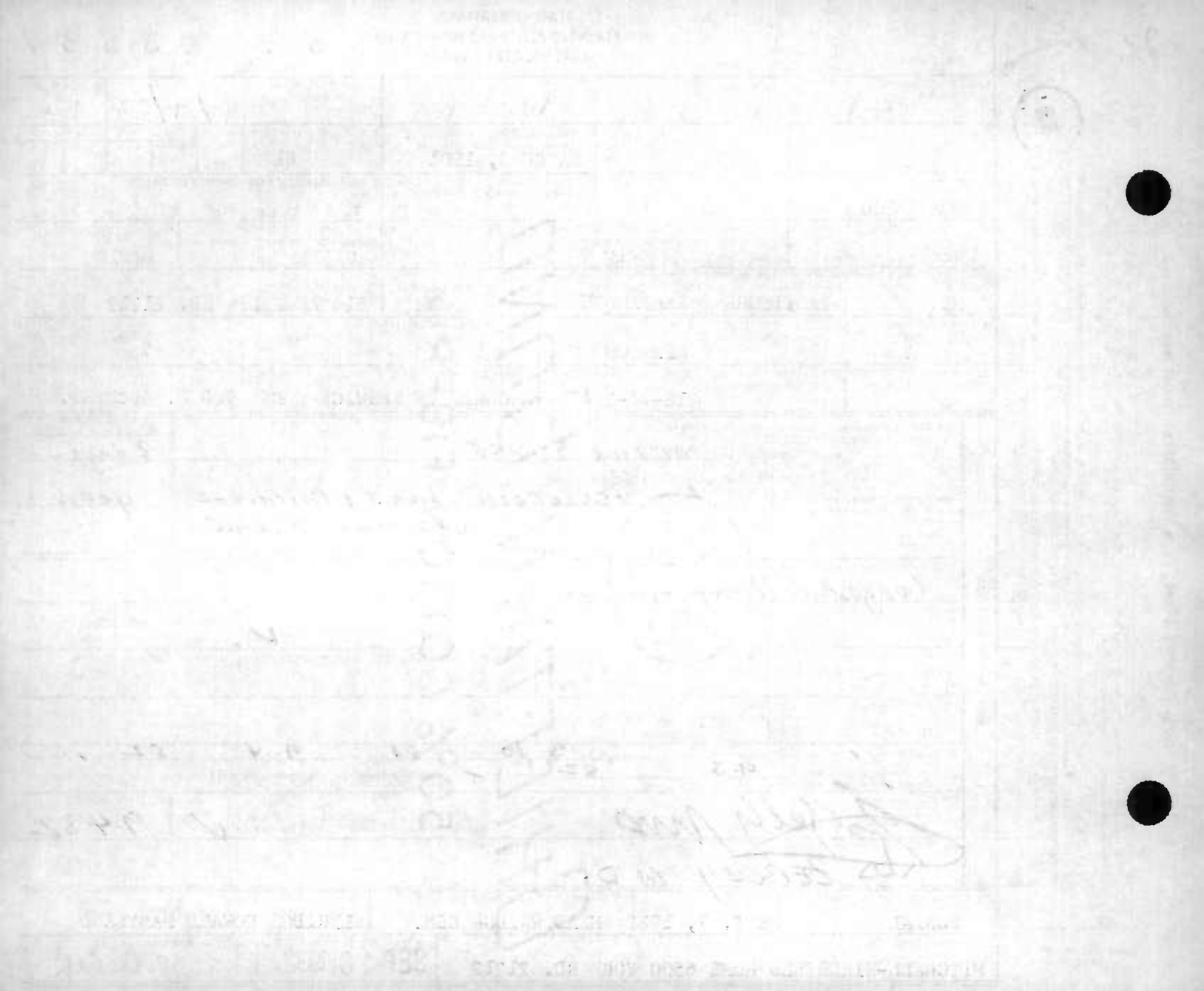
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                               |  |                                                                                                                             |  | 8 2 2 3 5 8 7<br>REG. NO.                                                                                                                                   |  |                                                                                                                            |                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Adalene H Weber</b>                                                                                                                                                                                                                                                                                         |  |                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9/4/82</b>                                                                                                        |  | 2b. HOUR<br><b>1:05 A.M.</b>                                                                                               |                                                               |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br><b>WHITE</b>                                                                                                     |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MARCH 8, 1901</b>                                                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.                                                                          |                                                               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD.                                                          |                                                               |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Keswick</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CLERK</b>                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>OFFICE</b>                                                                         |                                                               |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD.</b>                                                                                                                                                                                                                           |  |                                                                                                                             |  | 13b. COUNTY<br><b>BALTIMORE</b>                                                                                                                             |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                      |                                                               |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                    |  |                                                                                                                             |  | 13e. STREET ADDRESS<br><b>514 ANNESLIE RD. 21212</b>                                                                                                        |  |                                                                                                                            |                                                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>? HINKSON</b>                                                                                                                                                                                                                                                                                         |  |                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>? ? ?</b>                                                                                               |  |                                                                                                                            |                                                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.<br><b>213-74-2847</b>                                                                              |  | 17. INFORMANT<br>ADDRESS<br><b>RECORDS OF KESWICK HOME 700 W. 40th ST.</b>                                                                                  |  |                                                                                                                            |                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4140</b> IMMEDIATE CAUSE (a) <b>MASSIVE STROKE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ATHEROSCLEROTIC HEART &amp; PERIPHERAL VASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>years</b>                   |  |                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Congestive Heart Failure</b>                                                                                                                                                                            |  |                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                                            |                                                               |
| 19a. DATE OF OPERATION<br><b>9-4</b>                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                            |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)<br>21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                            |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |                                                               |
| 21d. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                                             |  | 21e. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                           |  |                                                                                                                                                             |  |                                                                                                                            |                                                               |
| 22a. I certify that (this hospital) attended the deceased from <b>3-10</b> , 19 <b>81</b> , to <b>9-4</b> , 19 <b>82</b> , that (we) last saw the deceased alive on <b>9-3</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did not) view the body after death. |  |                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                                            |                                                               |
| 22b. SIGNATURE<br><b>JOE ZEBLEY M.D.</b>                                                                                                                                                                                                                                                                                                           |  |                                                                                                                             |  | DEGREE<br><b>ATTENDING PHYSICIAN</b>                                                                                                                        |  | 22c. DATE SIGNED<br><b>9-4-82</b>                                                                                          |                                                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOE ZEBLEY M.D.</b>                                                                                                                                                                                                                                                                                    |  |                                                                                                                             |  | 22e. ADDRESS                                                                                                                                                |  |                                                                                                                            |                                                               |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br><b>SEPT. 7, 1982</b>                                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE CEM.</b>                                                                                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ELKRIDGE HOWARD MARYLAND</b>                                              |                                                               |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>MITCHELL-WIEDEFELD HOME 6500 YORK RD. 21212</b>                                                                                                                                                                                                                                                         |  |                                                                                                                             |  | 25. DATE REC'D. BY REGISTRAR 25. REGISTRAR'S SIGNATURE<br><b>SEP 10 1982</b> <b>Joan J. Conner</b>                                                          |  |                                                                                                                            |                                                               |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                 |                                                                                                           |                                                                                                                                                             |        |                                                                  |                   |                                   |                  |      |                      |
|-------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|------------------------------------------------------------------|-------------------|-----------------------------------|------------------|------|----------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)             |                                                                                                           | FIRST                                                                                                                                                       | MIDDLE | LAST                                                             | 2a. DATE OF DEATH | MONTH                             | DAY              | YEAR | 2b. HOUR             |
| WALKER                                          |                                                                                                           |                                                                                                                                                             |        | WELDON                                                           | 9/12/             | 82                                |                  |      | 5 <sup>10</sup> A.M. |
| 3. SEX                                          | 4. RACE                                                                                                   | 5. DATE OF BIRTH                                                                                                                                            |        | 6. AGE (IN YEARS LAST BIRTHDAY)                                  | IF UNDER 1 YEAR   |                                   | IF UNDER 24 HRS. |      |                      |
| Male                                            | Black                                                                                                     | 9 MONTH 25 DAY 12 YEAR                                                                                                                                      |        | 69                                                               | MONTHS DAYS       |                                   | HOURS MIN.       |      |                      |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY?                                                                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |        | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |                   |                                   |                  |      |                      |
| Virginia                                        | U.S.                                                                                                      |                                                                                                                                                             |        | Balto. City MD.                                                  |                   |                                   |                  |      |                      |
| 10. CITY OR TOWN OF DEATH                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                             |        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                   | 12b. KIND OF BUSINESS OR INDUSTRY |                  |      |                      |
| Balto.                                          | Lutheran Hosp.                                                                                            |                                                                                                                                                             |        |                                                                  |                   |                                   |                  |      |                      |

|                                                                                                  |  |                          |                                  |                                                                                      |                     |
|--------------------------------------------------------------------------------------------------|--|--------------------------|----------------------------------|--------------------------------------------------------------------------------------|---------------------|
| 13a. STATE                                                                                       |  | 13b. COUNTY              | 13c. CITY OR TOWN                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS |
| Md.                                                                                              |  |                          | Balto.                           |                                                                                      | 2626 Lafayette Ave. |
| 14. FATHER'S NAME                                                                                |  |                          | 15. MOTHER'S MAIDEN NAME         |                                                                                      |                     |
| FIRST MIDDLE LAST<br>Jackson Weldon                                                              |  |                          | FIRST MIDDLE LAST<br>Rosie Verne |                                                                                      |                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) |  | 16b. SOCIAL SECURITY NO. |                                  | 17. INFORMANT ADDRESS                                                                |                     |
| YES.                                                                                             |  | 216-09-5498              |                                  | Virgie Weldon 2626 W. Lafayette Ave                                                  |                     |

|                                                                                                                                                                                                                                                                                                                                  |  |                                                 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Atherosclerotic Heart Disease</u> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|

|                                                                                                                                                           |  |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes Mellitus</u> |  |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|

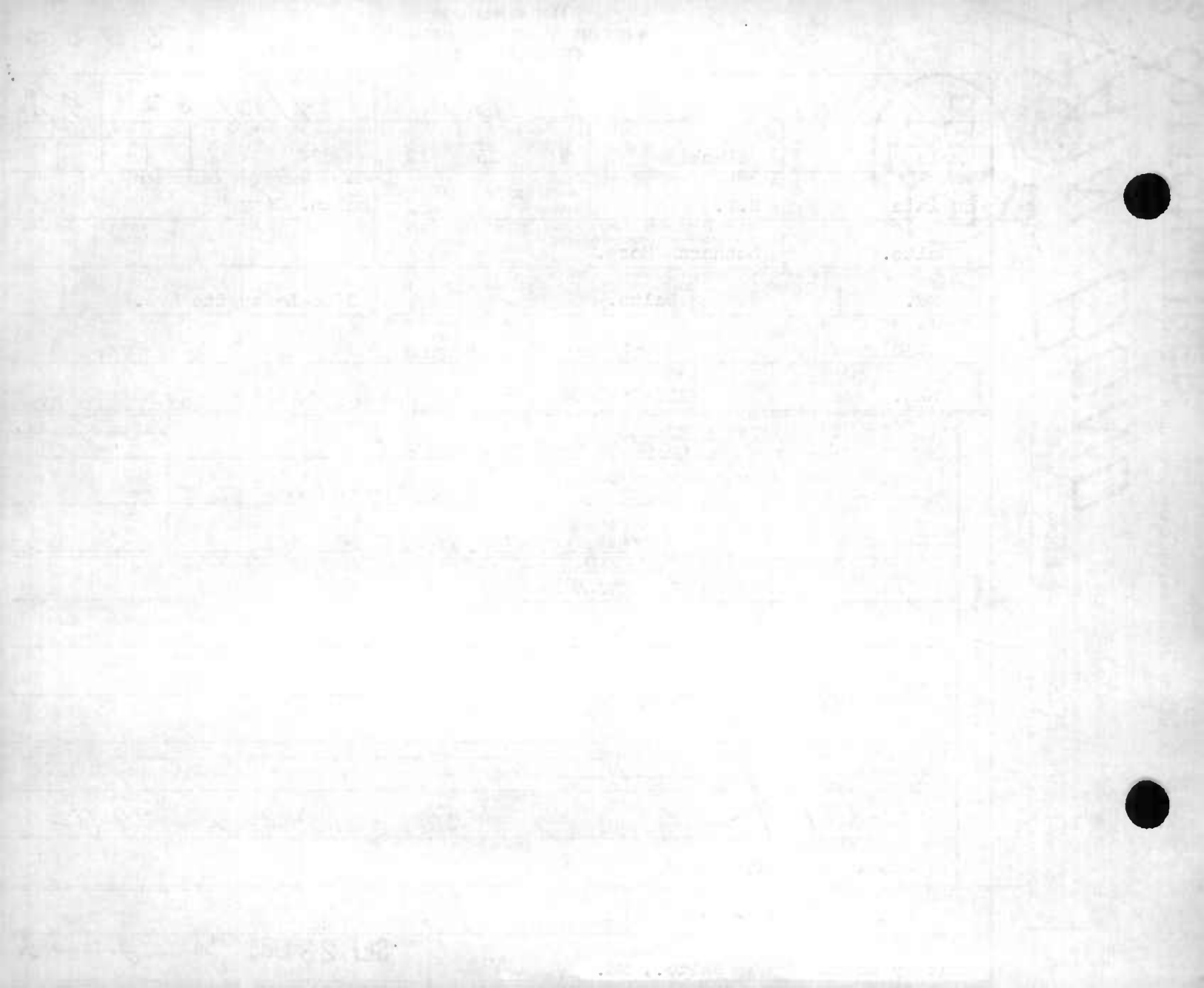
|                                                                                                                                                          |                                                                        |                                                                                |                                                                                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION                                                                                                                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                               |

|                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                      |                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                      |                             |
| 22b. SIGNATURE<br><u>CHENG CHUNG LIN</u>                                                                                                                                                                                                                                                                                          |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br>9/12/82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CHENG CHUNG LIN                                                                                                                                                                                                                                                                          |  | 22e. ADDRESS                                                                                                                                         |                             |

|                                              |           |                                                            |                                            |
|----------------------------------------------|-----------|------------------------------------------------------------|--------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY                         | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |
| BURIAL                                       | 9/18/82   | Arbutus mem. Pk                                            | Arbutus Md.                                |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS         |           | 25a. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE |                                            |
| Wm. C. March F/H 1151 E. North Ave.          |           | SEP 23 1982 <u>John J. Smith</u>                           |                                            |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 5 8 9

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                               |                                                                    |                                                                                                                                                             |                                                                                    |                                                                                                                            |                                                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MURIEL E. WELLS</b>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                               | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>9 4 82</b>                  |                                                                                                                                                             |                                                                                    | 2b. HOUR<br><b>6 A</b>                                                                                                     |                                                                              |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br><b>BL</b>                                                                                                                          |                                                                    | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>5 13 97</b>                                                                                                           |                                                                                    | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>86</b> YRS.                                                   |                                                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                    |                                                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALT CITY</b> MD.                                                               |                                                                              |
| 10. CITY OR TOWN OF DEATH<br><b>BALT</b>                                                                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY OF MD HOSPITAL</b> |                                                                    |                                                                                                                                                             |                                                                                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>(-)</b>                                             |                                                                              |
| 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                               |                                                                    |                                                                                                                                                             |                                                                                    |                                                                                                                            |                                                                              |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                      |  | 13b. COUNTY<br><b>Balt</b>                                                                                                                    |                                                                    | 13c. CITY OR TOWN<br><b>Balt</b>                                                                                                                            |                                                                                    | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                                                              |
| 13e. STREET ADDRESS<br><b>916 N. PAYSON ST.</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                               |                                                                    |                                                                                                                                                             |                                                                                    |                                                                                                                            |                                                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>James /Squir</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                               | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Nellie Tucker</b> |                                                                                                                                                             |                                                                                    |                                                                                                                            |                                                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                               | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>                             |                                                                                                                                                             | 17. INFORMANT <b>son-in-law</b> ADDRESS<br><b>HOWARD HAWKINS 916 N. PAYSON ST.</b> |                                                                                                                            |                                                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4275</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Severe congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Frequent Arrhythmias</b> |  |                                                                                                                                               |                                                                    |                                                                                                                                                             |                                                                                    |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>weeks</b><br><b>weeks</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>End-Stage Renal Disease. History of Frequent GI bleeds</b>                                                                                                                                                                                                                            |  |                                                                                                                                               |                                                                    |                                                                                                                                                             |                                                                                    |                                                                                                                            |                                                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                              |                                                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                                                                                    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                             |                                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                    |                                                                                                                            |                                                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        |                                                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                    |                                                                                                                            |                                                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/29</b> 19 <b>82</b> to <b>9/4</b> 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>9/3</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                     |  |                                                                                                                                               |                                                                    |                                                                                                                                                             |                                                                                    |                                                                                                                            |                                                                              |
| 22b. SIGNATURE<br><b>J R Schachner MD</b>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                               |                                                                    | DEGREE<br><b>MD</b>                                                                                                                                         |                                                                                    | 22c. DATE SIGNED<br><b>9/4/82</b>                                                                                          |                                                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. R. Schachner</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                               |                                                                    | 22e. ADDRESS<br><b>University of Md Hosp, Dept of Med.</b>                                                                                                  |                                                                                    |                                                                                                                            |                                                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br><b>9/9/82</b>                                                                                                                    |                                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King mem Pk</b>                                                                                                    |                                                                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                                                         |                                                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/ H 1101 E. North Ave.</b>                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                               |                                                                    | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 8 1982</b>                                                                                                          |                                                                                    | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                                                        |                                                                              |

11/11/48

80%



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 5 9 0

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |                                                                                                                                        |  |  |                                                                                                                                                             |  |  |                                                                                                                            |                                                                    |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                    |  |  | 2a. DATE OF DEATH                                                                                                                                           |  |  | 2b. HOUR                                                                                                                   |                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  | FIRST MIDDLE LAST<br>Gladys P. Wess                                                                                                    |  |  | MONTH DAY YEAR<br>September 11, 1982                                                                                                                        |  |  | 3:10P M                                                                                                                    |                                                                    |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  | 4. RACE<br>White                                                                                                                       |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>October 9, 1893                                                                                                       |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS.                                                                                 |                                                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                 |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                 |                                                                    |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired                                                                                 |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Textile                                                                               |                                                                    |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  | 13b. COUNTY<br>--                                                                                                                      |  |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Samuel Lingenfelter                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Jane Tucker                                                                           |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                  |  |  | 16b. SOCIAL SECURITY NO.<br>213-09-6097                                                                                    |                                                                    |  |
| 17. INFORMANT<br>Morman B. Wess Sr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  | ADDRESS<br>Baltimore, Md. 21228                                                                                                        |  |  | 2018 Westchester Avenue                                                                                                                                     |  |  |                                                                                                                            |                                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Coronary Artery Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Atherosclerotic Cardiovascular Disease</u>                                                                                                                                                                                |  |  |                                                                                                                                        |  |  |                                                                                                                                                             |  |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1-2 hours<br>Years |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)<br><u>Chronic Malabsorption Syndrome with refractory malnutrition</u>                                                                                                                                                                                                                                                                                                        |  |  |                                                                                                                                        |  |  |                                                                                                                                                             |  |  |                                                                                                                            |                                                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                         |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |  |                                                                                                                            |                                                                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                     |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                 |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |  |                                                                                                                            |                                                                    |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>September 11, 1982</u> , to <u>September 11, 1982</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>September 11, 1982</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (not) view the body after death. |  |  |                                                                                                                                        |  |  |                                                                                                                                                             |  |  |                                                                                                                            |                                                                    |  |
| 22b. SIGNATURE<br><u>Robert E. Boby, M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  | DEGREE<br>M.D.                                                                                                                         |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  |  | 22c. DATE SIGNED<br>9/11/82                                                                                                |                                                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert E. Boby, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  | 22e. ADDRESS<br>c/o Maryland General Hospital                                                                                          |  |  |                                                                                                                                                             |  |  |                                                                                                                            |                                                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  | 23b. DATE<br>9/15/82                                                                                                                   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Good Shepherd Cemetery                                                                                                |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Ellicott City Md.                                                            |                                                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Witzke P.A.                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  | ADDRESS<br>1630 Edmondson Avenue, Catonsville, Md. 21228                                                                               |  |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 14 1982                                                                                                                |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Carver</u>                                                                        |                                                                    |  |





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 5 9 1

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |                                            |                                                                                                                                                          |                                                                             |                                                                                                                         |                                   |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|-----------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>George Augustus West                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  | 2a. DATE OF DEATH MONTH DAY YEAR<br>9-4-82 |                                                                                                                                                          |                                                                             | 2b. HOUR<br>1 M                                                                                                         |                                   |  |
| 3. SEX<br>male                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br>Col.                                                                                                                                  |                                            | 5. DATE OF BIRTH MONTH DAY YEAR<br>April 18, 1939                                                                                                        |                                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>43 YRS.                                                                              |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore Md.                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                           |                                            | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                              |                                   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1212 Aisquith ST                       |                                            |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Unemployed |                                                                                                                         | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                   |  | 13b. COUNTY                                                                                                                                      |                                            | 13c. CITY OR TOWN<br>Baltimore                                                                                                                           |                                                                             | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                   |  |
| 14. FATHER'S NAME<br>Alfred Clinton West                                                                                                                                                                                                                                                                                 |  | 15. MOTHER'S MAIDEN NAME<br>Ethel Elizabeth Crowdy                                                                                               |                                            | 16. SOCIAL SECURITY NO.<br>22036-5405                                                                                                                    |                                                                             | 17. INFORMANT<br>Mrs. Beatrice Christian 3407 Ellwood Rd                                                                |                                   |  |
| 18. CAUSE OF DEATH Enter only one cause per line (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4029<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  | 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>COPD - Asthma |                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>YRS.                                                                                                     |                                                                             |                                                                                                                         |                                   |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                 |                                            | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                                                                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                       |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                          |                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |                                                                             |                                                                                                                         |                                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                              |                                            | 21f. LOCATION CITY OR TOWN COUNTY STATE                                                                                                                  |                                                                             |                                                                                                                         |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.  |  |                                                                                                                                                  |                                            |                                                                                                                                                          |                                                                             |                                                                                                                         |                                   |  |
| 22b. SIGNATURE<br>Richard F. Tyson M.D.                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                  |                                            | DEGREE<br>M.D.                                                                                                                                           |                                                                             | 22c. DATE SIGNED<br>9-9-82                                                                                              |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Richard F. Tyson                                                                                                                                                                                                                                                                |  |                                                                                                                                                  |                                            | 22e. ADDRESS<br>936 W. North Ave. Balt. Md. 21217                                                                                                        |                                                                             |                                                                                                                         |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                      |  | 23b. DATE<br>9-10-82                                                                                                                             |                                            | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt Zion Cem.                                                                                                       |                                                                             | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Lansdown Md                                                                  |                                   |  |
| 24. FUNERAL DIRECTOR NAME<br>Joseph L. Russ 2222 W. North Ave.                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |                                            | 25a. DATE REC'D. BY REGISTRAR<br>SEP 17 1982                                                                                                             |                                                                             |                                                                                                                         |                                   |  |

MEDICAL CERTIFICATION



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 5 9 2

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                         |                                                                 |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HENRY N WEST</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>SEPTEMBER 23 1982</b> |                                                                                                                                                             |                                                                                      | 2b. HOUR<br><b>12:15AM</b>                                                                      |                                                                                                                            |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br><b>BLACK</b>                                                                                                                 |                                                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAY 13 1915</b>                                                                                                    |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.                                               |                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                                                                                            |                                                                 | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD.                                    |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hosp</b> |                                                                 |                                                                                                                                                             |                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |                                                                                                                            |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY                                                                                                                             |                                                                 | 13c. CITY OR TOWN<br><b>BALTO</b>                                                                                                                           |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Nest</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lillian Mc Gillis</b>                                                               |                                                                 |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.                                                                                                                |                                                                 | 17. INFORMANT<br><b>Deneen Fields</b>                                                                                                                       |                                                                                      | ADDRESS<br><b>3438 Carriage Hill</b>                                                            |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO - RESPIRATORY ARREST</b><br><b>1874</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PENILE EPIDERMOID CARCINOMA WITH METASTASIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                         |                                                                 |                                                                                                                                                             |                                                                                      |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                                                                            |  |                                                                                                                                         |                                                                 |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                        |                                                                 |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                              |                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                                                      |                                                                                                 |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                  |                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                      |                                                                                                 |                                                                                                                            |
| 22a. I certify that (H) (this hospital) attended the deceased from <b>SEPT. 13</b> , 19 <b>82</b> , to <b>SEPT. 23</b> , 19 <b>82</b> , that (H) (we) last saw the deceased alive on <b>SEPT. 23</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.                                                  |  |                                                                                                                                         |                                                                 |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |
| 22b. SIGNATURE<br><b>Thomas S. Miller</b>                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                         |                                                                 | DEGREE<br><b>MD</b>                                                                                                                                         |                                                                                      | 22c. DATE SIGNED                                                                                |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>THOMAS S. MILLER, MD</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                         |                                                                 | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |                                                                                      |                                                                                                 |                                                                                                                            |
| 22e. ADDRESS<br><b>GOOD SAMARITAN HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                         |                                                                 |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><b>9/27/82</b>                                                                                                             |                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Aebatus Mem</b>                                                                                                    |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto MD</b>                                   |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Veeron R. Bailey</b>                                                                                                                                                                                                                                                                                                                                                                         |  | ADDRESS<br><b>1348 N. Calhoun</b>                                                                                                       |                                                                 | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 29 1982</b>                                                                                                         |                                                                                      | REGISTRAR'S SIGNATURE<br><b>John J. Linn</b>                                                    |                                                                                                                            |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is a summary of the work done during the year. This includes a description of the project, the objectives, and the results achieved. It also includes a list of the people who worked on the project and a list of the equipment used.

2. The second part of the report is a detailed description of the work done during the year. This includes a description of the methods used, the results obtained, and a discussion of the significance of the results. It also includes a list of the references used.

3. The third part of the report is a conclusion. This summarizes the main findings of the work and discusses the implications of these findings. It also includes a list of the references used.

4. The fourth part of the report is a list of the references used. This includes a list of the books, articles, and other sources of information used in the work.

5. The fifth part of the report is a list of the people who worked on the project. This includes a list of the names of the people and their positions.

6. The sixth part of the report is a list of the equipment used. This includes a list of the names of the equipment and their manufacturers.

7. The seventh part of the report is a list of the results achieved. This includes a list of the names of the results and their descriptions.

8. The eighth part of the report is a list of the objectives. This includes a list of the names of the objectives and their descriptions.

9. The ninth part of the report is a list of the methods used. This includes a list of the names of the methods and their descriptions.

10. The tenth part of the report is a list of the references used. This includes a list of the names of the references and their descriptions.

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item 15 #G571 9/10/82 ph

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 5 9 3  
REG. NO.

|                                                                             |  |                                                                                                                                        |  |                                                                                                                                                             |  |                                                                                                 |  |
|-----------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| FOR<br>1 - STATE<br>REGISTRAR                                               |  | 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Edward H. WHALEN                                                           |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>September 2, 1982                                                                                                    |  | 2b. HOUR<br>7:40 <sup>a</sup> M                                                                 |  |
| 3. SEX<br>Male                                                              |  | 4. RACE<br>Black                                                                                                                       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 21 97                                                                                                               |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85<br>YRS.                                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                    |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |  |
| 13a. STATE<br>Md.                                                           |  | 13b. COUNTY                                                                                                                            |  | 13c. CITY OR TOWN<br>Balto.                                                                                                                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Whalen                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elida Lucy Waynes Butler                                                              |  | 13e. STREET ADDRESS<br>2232 W. Baltimore St.                                                                                                                |  |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWI<br>220-02-0275                                                          |  | 17. INFORMANT<br>ADDRESS<br>Elida Whalen 2232 Baltimore St.                                                                                                 |  |                                                                                                 |  |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Septic Shock</u><br><u>5672</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Intra-abdominal abscess</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Post-operative Intra-abdominal bleeding</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>14 days<br>30 days |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                       |  |                                                                                      |  |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                       |  |                                                                                      |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION<br>July 2, 1982<br>September 1, 82                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Gastro-intestinal bleeding<br>Drainage of Intra-abdominal abscess |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |                                                                                                                            |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>July 2, 1982</u> to <u>September 2, 1982</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>September 2, 1982</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (we) did not view the body after death. |  |                                                                                                                       |  |                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><i>Barad</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                       |  | DEGREE<br>MD                                                                         |  | 22c. DATE SIGNED<br>9/2/82                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>c/o Maryland General Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                       |  | 22e. ADDRESS                                                                         |  |                                                                                                                            |  |

|                                                                           |  |                     |  |                                                     |  |                                                                |  |                                                     |  |  |  |
|---------------------------------------------------------------------------|--|---------------------|--|-----------------------------------------------------|--|----------------------------------------------------------------|--|-----------------------------------------------------|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                       |  | 23b. DATE<br>9/7/82 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Vet. Cem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crownsville, Md. |  |                                                     |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm C March F/H 1101 E. North Ave. |  |                     |  | 25a. DATE REC'D BY REGISTRAR<br>SEP 3 1982          |  |                                                                |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Conish</i> |  |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director or 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the local health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                               |                         | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                  |                                                                  | REG. NO. 8 2 2 3 5 9 4                                                                                                                                      |                           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><u>Jerome</u> <u>white</u>                                                                                                                                                                                                                                  |                         |                                                                                                                                                                                                                                                                                                                                                                       | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>9</u> <u>29</u> <u>82</u> |                                                                                                                                                             | 2b. HOUR<br><u>5</u> P.M. |
| 3. SEX<br><u>male</u>                                                                                                                                                                                                                                                                                                | 4. RACE<br><u>Black</u> | 5. DATE OF BIRTH MONTH DAY YEAR<br><u>2</u> <u>10</u> <u>65</u>                                                                                                                                                                                                                                                                                                       |                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>17</u> YRS.                                                                                                           |                           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Baltimore, md.</u>                                                                                                                                                                                                                                                   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                                                                                                                                                                                                                                                                                                            |                                                                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                           |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore</u> MD.                                                                                                                                                                                                                                                         |                         | 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>                                                                                                                                                                                                                                                                                                                         |                                                                  |                                                                                                                                                             |                           |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>University of Maryland Hospital</u>                                                                                                                                                                     |                         |                                                                                                                                                                                                                                                                                                                                                                       |                                                                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Student</u>                                                                             |                           |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><u>—</u>                                                                                                                                                                                                                                                                        |                         | 13a. STATE<br><u>md.</u>                                                                                                                                                                                                                                                                                                                                              |                                                                  |                                                                                                                                                             |                           |
| 13b. COUNTY<br><u>Baltimore</u>                                                                                                                                                                                                                                                                                      |                         | 13c. CITY OR TOWN<br><u>Baltimore</u>                                                                                                                                                                                                                                                                                                                                 |                                                                  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                |                           |
| 13e. STREET ADDRESS<br><u>1726 N. Chester St.</u>                                                                                                                                                                                                                                                                    |                         | 14. FATHER'S NAME FIRST MIDDLE LAST<br><u>Robert</u> <u>white</u>                                                                                                                                                                                                                                                                                                     |                                                                  |                                                                                                                                                             |                           |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><u>Virginia</u> <u>Ross</u>                                                                                                                                                                                                                                            |                         | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><u>No</u>                                                                                                                                                                                                                                                                                        |                                                                  |                                                                                                                                                             |                           |
| 16b. SOCIAL SECURITY NO.<br><u>135-57-900</u>                                                                                                                                                                                                                                                                        |                         | 17. INFORMANT<br><u>Mother</u>                                                                                                                                                                                                                                                                                                                                        |                                                                  |                                                                                                                                                             |                           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><u>3591</u><br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Pulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Duchenne's muscular Dystrophy</u> |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 minutes</u><br><u>1 month</u><br><u>13 years</u>                                                                                                                                                                                                                                                                 |                                                                  |                                                                                                                                                             |                           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                  |                         |                                                                                                                                                                                                                                                                                                                                                                       |                                                                  |                                                                                                                                                             |                           |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                               |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                                      |                                                                  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                           |                           |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                              |                         | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                    |                                                                  |                                                                                                                                                             |                           |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. <u>19</u>                                                                                                                                                                                                                                                       |                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                                                                                                                                                        |                                                                  |                                                                                                                                                             |                           |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK                                                                                                                                                                                                               |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                                                                   |                                                                  |                                                                                                                                                             |                           |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                       |                         | 22a. I certify that (I) (this hospital) attended the deceased from <u>8/29/82</u> , 19 <u>82</u> , to <u>9/29</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>9/29</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                  |                                                                                                                                                             |                           |
| 22b. SIGNATURE<br><u>Georgette A. Sims M.D.</u>                                                                                                                                                                                                                                                                      |                         | DEGREE<br><u>Georgette A. Sims M.D.</u>                                                                                                                                                                                                                                                                                                                               |                                                                  | 22c. DATE SIGNED<br><u>9/29/82</u>                                                                                                                          |                           |
| 22d. PHYSICIAN'S NAME (NAME OR PRINT)<br><u>Georgette A. Sims M.D.</u>                                                                                                                                                                                                                                               |                         | 22e. ADDRESS<br><u>22 S. Greene St.</u>                                                                                                                                                                                                                                                                                                                               |                                                                  |                                                                                                                                                             |                           |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>BURIAL</u>                                                                                                                                                                                                                                                           |                         | 23b. DATE<br><u>10/4/82</u>                                                                                                                                                                                                                                                                                                                                           |                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mount Calvary Cem</u>                                                                                              |                           |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br><u>Baltimore</u> <u>Md.</u>                                                                                                                                                                                                                                               |                         | 24. FUNERAL DIRECTOR NAME ADDRESS<br><u>Wm. C. varch F/H 1101 E. North Avenue</u>                                                                                                                                                                                                                                                                                     |                                                                  |                                                                                                                                                             |                           |
| 25a. DATE REC'D. BY REGISTRAR<br><u>1-1982</u>                                                                                                                                                                                                                                                                       |                         | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Carver</u>                                                                                                                                                                                                                                                                                                                   |                                                                  |                                                                                                                                                             |                           |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please may be dictated by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified after the death.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 5 9 5  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                     |                                                                                                                                                             |                                                                                            |                                                                         |                                                                                                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MARGARET F. WHITE</b>                                                                                                                                                                                                                                                                                        |                                                                                                                                     |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>SEP. 25, 1982</b>                                   |                                                                         | 2b. HOUR<br><b>M</b>                                                                                                    |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                  | 4. RACE<br><b>WHITE</b>                                                                                                             | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>AUG 4 1906</b>                                                                                                        |                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.                       | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                          |                                                                         |                                                                                                                         |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                            | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2836 INGLEWOOD AVE</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>REAL ESTATE BROKER</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SELF EMPL.</b>                  |                                                                                                                         |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                            |                                                                                                                                     |                                                                                                                                                             | 13b. COUNTY<br><b>BALTIMORE</b>                                                            | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John SPERL</b>                                                                                                                                                                                                                                                                                                                 |                                                                                                                                     |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>FLORENCE E.</b>                           |                                                                         |                                                                                                                         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                           |                                                                                                                                     | 16b. SOCIAL SECURITY NO.<br><b>219-14-1339</b>                                                                                                              |                                                                                            | 17. INFORMANT ADDRESS<br><b>FAMILY RECORDS</b>                          |                                                                                                                         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>2506 IMMEDIATE CAUSE (a) <b>M. I.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pericard V. Deane</b> |                                                                                                                                     |                                                                                                                                                             |                                                                                            |                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>25 years</b><br><b>10 years</b>                                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>NO</b>                                                                                                                                                                                                                               |                                                                                                                                     |                                                                                                                                                             |                                                                                            |                                                                         |                                                                                                                         |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                            | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                       |                                                                                                                                     | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>                                                                                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)             |                                                                         |                                                                                                                         |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                   |                                                                                                                                     | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                         | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                             |                                                                         |                                                                                                                         |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1957</b> , 19____, to <b>Sept</b> , 19____, that (I) (we) last saw the deceased alive on <b>9/20/82</b> , 19____, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                           |                                                                                                                                     |                                                                                                                                                             |                                                                                            |                                                                         |                                                                                                                         |
| 22b. SIGNATURE<br><b>Harold H Burns</b>                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                     | DEGREE<br><b>M.D.</b>                                                                                                                                       |                                                                                            | 22c. DATE SIGNED<br><b>9-27-82</b>                                      |                                                                                                                         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HAROLD H. BURNS, M.D.</b>                                                                                                                                                                                                                                                                                                    |                                                                                                                                     | 22e. ADDRESS<br><b>8106 HARFORD ROAD</b>                                                                                                                    |                                                                                            |                                                                         |                                                                                                                         |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>ENTOMBMENT</b>                                                                                                                                                                                                                                                                                                           | 23b. DATE<br><b>SEP 28, 82</b>                                                                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARK WOOD</b>                                                                                                      |                                                                                            | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE COUNTY M.D.</b> |                                                                                                                         |
| 24. FUNERAL DIRECTOR NAME<br><b>EVANG FUNERAL CHAPEL</b>                                                                                                                                                                                                                                                                                                                 |                                                                                                                                     | ADDRESS<br><b>8300 HARFORD RD</b>                                                                                                                           |                                                                                            | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 1 - 1982</b>                    | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canine</b>                                                                     |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, it should be detached for use at the burial. Please note: This certificate is to be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHWH-16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                |  | REG. NO. 8 2 2 3 5 9 6                                                                                                                                      |  |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MARIE M. WHITE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>SEPTEMBER 22, 1982</b>                                                                                               |  | 2b. HOUR<br><b>03:30AM</b>                                                                                                 |  |
| 3. SEX<br><b>F.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br><b>BLK</b>                                                                                                                          |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 - 19 - 27</b>                                                                                                    |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS.<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.            |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                                                                                                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                           |  |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY                                                                                                                                    |  | 13c. CITY OR TOWN<br><b>BALTO</b>                                                                                                                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Chesler Larkins</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Carrie Turner</b>                                                                          |  | 13e. STREET ADDRESS<br><b>910 N. Carrollton Ave</b>                                                                                                         |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.                                                                                                                       |  | 17. INFORMANT ADDRESS<br><b>CARRIE LARKINS 910 CARROLLTON AVE</b>                                                                                           |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1509 IMMEDIATE CAUSE (a) Respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Esophageal cancer metastatic to liver</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |                                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                               |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/30/82</b> , 19 <b>82</b> , to <b>9/22</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>9/22</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                 |  |                                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Michael Schindler</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>9/22/82</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MICHAEL SCHINDLER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>                                                                                                               |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br><b>9/25/82</b>                                                                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Mem PK.</b>                                                                                                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO MD</b>                                                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>VERNON R. BAILEY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                |  | ADDRESS<br><b>1348 N. Calhoun St</b>                                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 29 1982</b>                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                                                                                         |  |                                                                                                                            |  |

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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 5 9 7

REG. NO.

|                                                                                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                          |                                                  |                                                               |                                                                                |                                                                                                                                                       |                                                                     |                                                                     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                      |                                                                                                        |                                                                                                                                                          | 2a. DATE OF DEATH                                |                                                               |                                                                                | 2b. HOUR                                                                                                                                              |                                                                     |                                                                     |
| ALDONIA WHITEHURST                                                                                                                                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                          | SEPTEMBER 02, 1982                               |                                                               |                                                                                | 10:24AM                                                                                                                                               |                                                                     |                                                                     |
| 3. SEX                                                                                                                                                                                                                                                                                                                                   | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)                  |                                                               |                                                                                | IF UNDER 1 YEAR                                                                                                                                       |                                                                     |                                                                     |
| Female                                                                                                                                                                                                                                                                                                                                   | Black                                                                                                  | MONTH 2 DAY 23 YEAR 32                                                                                                                                   | 50 YRS.                                          |                                                               |                                                                                | MONTHS DAYS HOURS MIN.                                                                                                                                |                                                                     |                                                                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |                                                                                |                                                                                                                                                       |                                                                     |                                                                     |
| N.C.                                                                                                                                                                                                                                                                                                                                     | USA                                                                                                    |                                                                                                                                                          |                                                  | BALTIMORE CITY MD.                                            |                                                                                |                                                                                                                                                       |                                                                     |                                                                     |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          |                                                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                |                                                                                                                                                       | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                                                                     |
| BALTIMORE                                                                                                                                                                                                                                                                                                                                | THE JOHNS HOPKINS HOSPITAL                                                                             |                                                                                                                                                          |                                                  |                                                               |                                                                                |                                                                                                                                                       |                                                                     |                                                                     |
| 13a. STATE                                                                                                                                                                                                                                                                                                                               |                                                                                                        |                                                                                                                                                          | 13b. COUNTY                                      |                                                               | 13c. CITY OR TOWN                                                              |                                                                                                                                                       | 13d. INSIDE CITY LIMITS?                                            |                                                                     |
| Md.                                                                                                                                                                                                                                                                                                                                      |                                                                                                        |                                                                                                                                                          |                                                  |                                                               | Balto.                                                                         |                                                                                                                                                       | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                     |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          | 15. MOTHER'S MAIDEN NAME                         |                                                               |                                                                                | 13e. STREET ADDRESS                                                                                                                                   |                                                                     |                                                                     |
| Joseph King                                                                                                                                                                                                                                                                                                                              |                                                                                                        |                                                                                                                                                          | Mary Leary                                       |                                                               |                                                                                | 1517 N. Montford Avenue                                                                                                                               |                                                                     |                                                                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          | 16b. SOCIAL SECURITY NO.                         |                                                               | 17. INFORMATION ADDRESS                                                        |                                                                                                                                                       |                                                                     |                                                                     |
| No                                                                                                                                                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                          |                                                  |                                                               | Janice West 1101 Gorsuch Ave.                                                  |                                                                                                                                                       |                                                                     |                                                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                |                                                                                                        |                                                                                                                                                          |                                                  |                                                               |                                                                                |                                                                                                                                                       |                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                  |                                                               |                                                                                |                                                                                                                                                       |                                                                     |                                                                     |
| IMMEDIATE CAUSE (a) Hypotension                                                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                          |                                                  |                                                               |                                                                                |                                                                                                                                                       |                                                                     | 8 hrs                                                               |
| 5713 DUE TO, OR AS A CONSEQUENCE OF (b) Gastrointestinal Bleeding                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          |                                                  |                                                               |                                                                                |                                                                                                                                                       |                                                                     | ≥ 24 hrs                                                            |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Alcoholic Liver Disease                                                                                                                                                                                |                                                                                                        |                                                                                                                                                          |                                                  |                                                               |                                                                                |                                                                                                                                                       |                                                                     | ≥ 4 yrs                                                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                          |                                                  |                                                               |                                                                                |                                                                                                                                                       |                                                                     |                                                                     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |                                                               |                                                                                | 20a. AUTOPSY?                                                                                                                                         |                                                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |
|                                                                                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                          |                                                  |                                                               |                                                                                | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                                                                     | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                          | 21b. TIME OF INJURY                              |                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                                                       |                                                                     |                                                                     |
|                                                                                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                          | HOUR A.M. MONTH DAY YEAR                         |                                                               |                                                                                |                                                                                                                                                       |                                                                     |                                                                     |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                                     |                                                                                                        |                                                                                                                                                          | 21e. PLACE OF INJURY                             |                                                               | 21f. LOCATION                                                                  |                                                                                                                                                       |                                                                     |                                                                     |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                                                               | STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                                                       |                                                                     |                                                                     |
| 22a. I certify that (we) (this hospital) attended the deceased from 9/1/82, 19, to 9/2/82, 19, that (we) last saw the deceased alive on 9/2/82, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death. <input checked="" type="checkbox"/> |                                                                                                        |                                                                                                                                                          |                                                  |                                                               |                                                                                |                                                                                                                                                       |                                                                     |                                                                     |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                          |                                                  |                                                               |                                                                                | DEGREE                                                                                                                                                |                                                                     | 22c. DATE SIGNED                                                    |
| A. Beamer MD                                                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                  |                                                               |                                                                                | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                     | 9/2/82                                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                          |                                                  |                                                               |                                                                                | 22e. ADDRESS                                                                                                                                          |                                                                     |                                                                     |
| ANDREW D. BEAMER MD                                                                                                                                                                                                                                                                                                                      |                                                                                                        |                                                                                                                                                          |                                                  |                                                               |                                                                                | Johns Hopkins Hosp. Baltimore MD                                                                                                                      |                                                                     |                                                                     |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                |                                                                                                        |                                                                                                                                                          | 23b. DATE                                        |                                                               | 23c. NAME OF CEMETERY OR CREMATORY                                             |                                                                                                                                                       | 23d. LOCATION                                                       |                                                                     |
| Burial                                                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                          | 9/8/82                                           |                                                               | Baltimore Nat. Cem.                                                            |                                                                                                                                                       | CITY OR TOWN COUNTY STATE                                           |                                                                     |
|                                                                                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                          |                                                  |                                                               | Balto., Md.                                                                    |                                                                                                                                                       |                                                                     |                                                                     |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                     |                                                                                                        |                                                                                                                                                          |                                                  |                                                               |                                                                                | 25a. DATE REC'D. BY REGISTRAR                                                                                                                         |                                                                     | 25b. REGISTRAR'S SIGNATURE                                          |
| Wm C March F/H 1101 E. North Ave.                                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          |                                                  |                                                               |                                                                                | SEP 3 1982                                                                                                                                            |                                                                     | John J. Conner                                                      |





SEP 11 JUL 5  
MEDIA, TECHNICAL  
SERVICES

11010

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 4 may be retained by the hospital or attending physician.

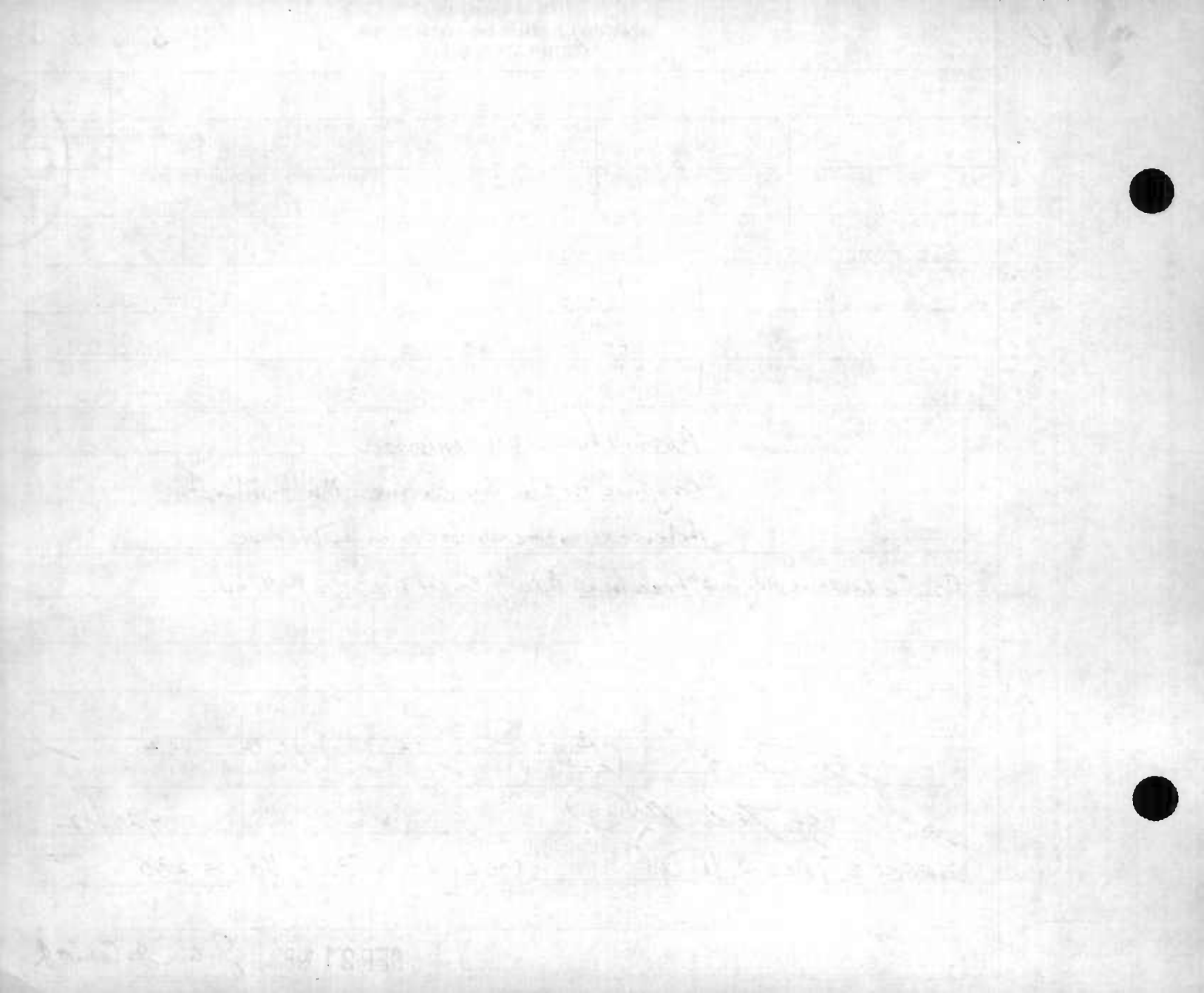
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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2037 BP

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                                                                   |  | 8 2 2 3 5 9 8<br>REG. NO.                       |  |          |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|-------------------------------------------------------------------|--|-------------------------------------------------|--|----------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                           |  |                                                                                                                                                             |  | 2a. DATE OF DEATH                                                   |  |                                                                   |  | MONTH DAY YEAR                                  |  | 7b. HOUR |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                           |  |                                                                                                                                                             |  | FELTON L. WHITFIELD                                                 |  |                                                                   |  | 9 16 82                                         |  | M        |  |
| 3 SEX                                                                                                                                                                                                                                                                                                                                                                 |  | 4 RACE                                                                                                    |  | 5. DATE OF BIRTH                                                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                                                   |  | IF UNDER 24 HRS.                                |  |          |  |
| Male                                                                                                                                                                                                                                                                                                                                                                  |  | Black                                                                                                     |  | MONTH DAY YEAR<br>3 3 05                                                                                                                                    |  | 77 YRS.                                                             |  | MONTHS DAYS                                                       |  | HOURS MIN.                                      |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                                                   |  |                                                 |  |          |  |
| N. Carolina                                                                                                                                                                                                                                                                                                                                                           |  | USA                                                                                                       |  |                                                                                                                                                             |  | Baltimore City, MD.                                                 |  |                                                                   |  |                                                 |  |          |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR INDUSTRY                                 |  |                                                 |  |          |  |
| /Baltimore                                                                                                                                                                                                                                                                                                                                                            |  | Lutheran Hospital                                                                                         |  |                                                                                                                                                             |  |                                                                     |  |                                                                   |  |                                                 |  |          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                               |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                                                                   |  |                                                 |  |          |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                            |  | 13b. COUNTY                                                                                               |  | 13c. CITY OR TOWN                                                                                                                                           |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS                                               |  |                                                 |  |          |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                           |  | Baltimore                                                                                                                                                   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 3300 W. Mulberry St.                                              |  |                                                 |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                |  |                                                                                                           |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                                                                               |  |                                                                     |  |                                                                   |  |                                                 |  |          |  |
| Manuel Whitfield                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                           |  | Maggie Whitfield                                                                                                                                            |  |                                                                     |  |                                                                   |  |                                                 |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                                                                                                                                                                                                                                                                      |  |                                                                                                           |  | 16b. SOCIAL SECURITY NO.                                                                                                                                    |  | 17. INFORMANT                                                       |  | ADDRESS                                                           |  |                                                 |  |          |  |
| No                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                           |  | N/A                                                                                                                                                         |  | Laura Moore                                                         |  | 3300 W. Mulberry St.                                              |  |                                                 |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Organic Brain Syndrome - Multi-infarct</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Arteriosclerotic Cerebrovascular Disease</u>                           |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                                                                   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><u>C5-C6 quadraplegia Trauma, Adult Onset Diabetes Mellitus.</u>                                                                                                                                                              |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                                                                   |  |                                                 |  |          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  |                                                                                                                                                             |  | 20a. AUTOPSY?                                                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |  |                                                 |  |          |  |
|                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                           |  |                                                                                                                                                             |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |                                                 |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART I OR PART 2)                                                                              |  |                                                                     |  |                                                                   |  |                                                 |  |          |  |
|                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                                                                   |  |                                                 |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                     |  |                                                                   |  |                                                 |  |          |  |
|                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                                                                   |  |                                                 |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 5</u> , 19 <u>82</u> , to <u>Sept 16</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>Aug 5</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, just did not view the body after death.) |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                     |  |                                                                   |  |                                                 |  |          |  |
| 22b. SIGNATURE<br><u>George Taler M.D.</u>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                           |  |                                                                                                                                                             |  | DEGREE                                                              |  | 22c. DATE SIGNED<br><u>9/20/82</u>                                |  |                                                 |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                           |  |                                                                                                                                                             |  | 22e. ADDRESS                                                        |  |                                                                   |  |                                                 |  |          |  |
| GEORGE TALER, M.D.                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                           |  |                                                                                                                                                             |  | 600 Light St. Balt. Md. 21230                                       |  |                                                                   |  |                                                 |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |                                                                   |  |                                                 |  |          |  |
| BURIAL                                                                                                                                                                                                                                                                                                                                                                |  | 9/20/82                                                                                                   |  | King Memorial Pk.                                                                                                                                           |  | Baltimore Md.                                                       |  |                                                                   |  |                                                 |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE                                        |  |                                                 |  |          |  |
| Wm. C. march F/H 1101 E. North Avenue                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                           |  |                                                                                                                                                             |  | SEP 21 1982                                                         |  | <u>John J. Conner</u>                                             |  |                                                 |  |          |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 5 9 9

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|                                                         |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                   |  |                                                                  |  |                                         |  |
|---------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------|--|------------------------------------------------------------------|--|-----------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JAMES</b>     |  | FIRST<br><b>WHITEFIELD</b>                                                                                                         |  | MIDDLE                                                                                                                                                      |  | LAST                                                              |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 9 1982</b>           |  | 2b. HOUR<br><b>12<sup>15</sup> P.M.</b> |  |
| 3. SEX<br><b>MALE</b>                                   |  | 4. RACE<br><b>BLACK</b>                                                                                                            |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 12 1920</b>                                                                                                      |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.                 |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                        |  | IF UNDER 24 HRS.                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>USA</b> |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                         |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD. |  |                                                                  |  |                                         |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |  |                                                                                                                                                             |  |                                                                   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY       |  |

|                                                                                                                    |  |                                                                               |  |                                                                      |  |                                                                                                 |  |                                                  |  |  |  |
|--------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|--------------------------------------------------|--|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b> |  | 13b. COUNTY<br><b>BALTIMORE</b>                                               |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>8319 INGLESIDE AVE</b> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Mack</b>                                                              |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sallie Bullock</b>        |  |                                                                      |  |                                                                                                 |  |                                                  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>UNKNOWN</b>                             |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>244 12 2439</b> |  | 17. INFORMANT ADDRESS<br><b>Vashti Whitfield 3319 Ingleside Ave.</b> |  |                                                                                                 |  |                                                  |  |  |  |

|                                                                                                                                                                                                                                                                                                                                                                              |  |                                              |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SMALL CELL CA OF LUNG</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|

|                                                                                                                                                                        |  |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>CARDIO MYOPATHY S/P CVA</b> |  |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|

|                                                                                                                                                          |  |                                                                        |  |                                                                                      |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |                                                                                                                            |  |

|                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/25/82</b> to <b>9/9/82</b> , that (I) (we) lost saw the deceased alive on <b>9/9</b> , 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|

|                                                                 |  |                                   |  |                                                                                                                                            |  |                                   |  |
|-----------------------------------------------------------------|--|-----------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------|--|
| 22b. SIGNATURE<br><b>JEFFREY M. MOLL</b>                        |  | DEGREE<br><b>MP</b>               |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>9/9/82</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JEFFREY M. MOLL</b> |  | 22e. ADDRESS<br><b>SINAI Hosp</b> |  |                                                                                                                                            |  |                                   |  |

|                                                            |  |                             |  |                                                            |  |                                                                    |  |
|------------------------------------------------------------|--|-----------------------------|--|------------------------------------------------------------|--|--------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>9/14/82</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Mem. Pk.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Co. MD</b> |  |
|------------------------------------------------------------|--|-----------------------------|--|------------------------------------------------------------|--|--------------------------------------------------------------------|--|

|                                                                                     |  |                                                     |  |                                         |  |
|-------------------------------------------------------------------------------------|--|-----------------------------------------------------|--|-----------------------------------------|--|
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H, Inc. 1101 E. North</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 15 1982</b> |  | 25b. SIGNATURE<br><b>John J. Casper</b> |  |
|-------------------------------------------------------------------------------------|--|-----------------------------------------------------|--|-----------------------------------------|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the 7 copies of the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

James G. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to autops.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 6 0 0

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                    |                                                                                                                                                             |                                                                                              |                                                                                                 |                                                       |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BEN JAMIN WHITMAN</b>                                                                                                                                                                                                                                                                                         |                                                                                                                                    | 2a. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>19</b> YEAR <b>82</b>                                                                                            |                                                                                              | 2b. HOUR<br><b>8:26 PM</b>                                                                      |                                                       |
| 3. SEX<br><b>M</b> ALE                                                                                                                                                                                                                                                                                                                               | 4. RACE<br><b>C</b> CAUCASIAN                                                                                                      | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>28</b> YEAR <b>98</b>                                                                                             |                                                                                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.                                               |                                                       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>                                                                                                                                                                                                                                                                                           | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                         | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |                                                       |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PROPRIETOR</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DRY GOODS</b> |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                        |                                                                                                                                    | 13b. COUNTY<br><b>BALTIMORE</b>                                                                                                                             | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                        | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                       |
| 14. FATHER'S NAME<br><b>NACHUM</b> MIDDLE<br><b>WHITMAN</b>                                                                                                                                                                                                                                                                                          |                                                                                                                                    | 15. MOTHER'S MAIDEN NAME<br><b>SARAH</b> MIDDLE<br><b>SMULOVITZ</b>                                                                                         |                                                                                              |                                                                                                 |                                                       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NAME UNKNOWN) <b>NO</b>                                                                                                                                                                                                                                                                        |                                                                                                                                    | 16b. SOCIAL SECURITY NO.<br><b>217-32-8850</b>                                                                                                              |                                                                                              | 17. INFORMANT<br><b>MRS. ESTHER WHITMAN</b> ADDRESS<br><b>6611 EBERLE DR., APT. 104 #21215</b>  |                                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <b>ACUTE Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiac Arrest.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) |                                                                                                                                    |                                                                                                                                                             |                                                                                              |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a                                                                                                                                                                                                                     |                                                                                                                                    |                                                                                                                                                             |                                                                                              |                                                                                                 |                                                       |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                               |                                                                                                                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                              |                                                                                                                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |                                                                                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                   |                                                                                                                                    | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                              | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                       |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                          |                                                                                                                                    |                                                                                                                                                             |                                                                                              |                                                                                                 |                                                       |
| 22b. SIGNATURE<br><b>D. S. PATEL</b>                                                                                                                                                                                                                                                                                                                 |                                                                                                                                    | DEGREE<br><b>MD.</b>                                                                                                                                        |                                                                                              | 22c. DATE SIGNED<br><b>9.19.82.</b>                                                             |                                                       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D. S. PATEL</b>                                                                                                                                                                                                                                                                                          |                                                                                                                                    | 22e. ADDRESS<br><b>SINAI HOSPITAL</b>                                                                                                                       |                                                                                              |                                                                                                 |                                                       |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                        |                                                                                                                                    | 23b. DATE<br><b>SEPT. 20, 1982</b>                                                                                                                          |                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH EL MEMORIAL PARK</b>                              |                                                       |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>                                                                                                                                                                                                                                                                                |                                                                                                                                    | 25a. DATE REC'D BY REGISTRAR<br><b>SEP 23 1982</b>                                                                                                          |                                                                                              | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                             |                                                       |
| 6010 REISTERSTOWN RD.                                                                                                                                                                                                                                                                                                                                |                                                                                                                                    | BALTO., MD                                                                                                                                                  |                                                                                              | 21215                                                                                           |                                                       |

0 12 24 8 20

WHITMAN

BEN

143

80

2

10

10

ACUTE HYPOCALCAEMIA

(Calcium level)

100

Defect

D 2

CALCIUM



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                |  |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                |  |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Joan E. Whitson                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                   |  |                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>September 12, 1982                      |  | 2b. HOUR<br>3:15 A.M.                                                                                                      |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br>White                                                                                                                  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 26, 1987                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>95 YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>England                                                                                                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                            |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                    |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2020 Greenberry Road |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Home Maker |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home                                                                              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                   |  |                                                                                                                                                             |  | 13b. COUNTY                                                                    |  | 13c. CITY OR TOWN<br>Baltimore                                                                                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown                                                                                                                                                                                                                                                                                                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNKNOWN                                                                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  |                                                                                |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-18-8512 D                                                          |  | 17. INFORMANT<br>ADDRESS<br>Ruth M. Whitson Same as #13.                                                                                                    |  |                                                                                |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute heart attack</u><br>4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aseptic</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                |  |                                                                                                                            |  |
| MEDICAL CERTIFICATION                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                  |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b OR PART 2)                                                                                     |  |                                                                                |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK                                                                                                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                            |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>1963 Sept 12 82                                                                                        |  |                                                                                |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 29 1982</u> to <u>Sept 12 1982</u> that (I) (we) last saw the deceased alive on <u>Sept 29 1982</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we last did not view the body after death)                                                                                                                               |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>William G. Helfrich, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                   |  | 22c. DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |                                                                                |  | 22d. DATE SIGNED<br>8/13/82                                                                                                |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William G. Helfrich, M.D.                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                   |  | 22f. ADDRESS<br>5006 Roland Ave. Baltimore, Md. 21210                                                                                                       |  |                                                                                |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                           |  | 23b. DATE<br>Sept. 15, 1982                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cem.                                                                                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pikesville Balto., Md.           |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc. Towson, Md. 21204                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                   |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 14 1982                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel                                   |  |                                                                                                                            |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                   |  |                                                                                                                                                             |                                                                          |                                                                                                 |                                                                                                   |                                                                                                                                            |  | 8 2 2 3 6 0 2<br>REG. NO.                                                                                                  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  |                                                                                                                                                             |                                                                          |                                                                                                 |                                                                                                   |                                                                                                                                            |  |                                                                                                                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Annie B. Whitten</i>                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                   |  |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>9-18-82</i>                       |                                                                                                 |                                                                                                   | 2b. HOUR<br><i>4 P M</i>                                                                                                                   |  |                                                                                                                            |  |
| 3. SEX<br><i>Female</i>                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br><i>Black</i>                                                                                                                           |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>6 6 1897</i>                                                                                                       |                                                                          | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>85</i> YRS.                                               |                                                                                                   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                                  |  |                                                                                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Virginia</i>                                                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>                                                                                                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City, Maryland</i>                         |                                                                                                   |                                                                                                                                            |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>John L. Deaton Medical Center</i> |  |                                                                                                                                                             |                                                                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>            |                                                                                                   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Home</i>                                                                                           |  |                                                                                                                            |  |
| 13a. STATE<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                                                     |  | 13b. COUNTY                                                                                                                                       |  | 13c. CITY OR TOWN<br><i>Baltimore</i>                                                                                                                       |                                                                          | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                   | 13e. STREET ADDRESS<br><i>3817 Grantley Rd.<br/>Baltimore, Maryland 21215</i>                                                              |  |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Aaron Smith</i>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                   |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Caroline Johnson</i> |                                                                                                 |                                                                                                   |                                                                                                                                            |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i>                                                                                                                                                                                                                                                                     |  |                                                                                                                                                   |  |                                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br><i>234-42-8738</i>                           |                                                                                                 | 17. INFORMANT<br><i>Baltimore, Maryland 21215</i><br><i>Miss Carolyn Boston 3817 Grantley Rd.</i> |                                                                                                                                            |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Heart failure</i><br><i>4292</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>ASCLD</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>years</i> |  |                                                                                                                                                   |  |                                                                                                                                                             |                                                                          |                                                                                                 |                                                                                                   |                                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>12 hours</i>                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><i>CBS. decubitus</i>                                                                                                                                                                                                                     |  |                                                                                                                                                   |  |                                                                                                                                                             |                                                                          |                                                                                                 |                                                                                                   |                                                                                                                                            |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                          |                                                                                                 |                                                                                                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                          |  |                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>                                                                                           |                                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                                   |                                                                                                                                            |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                         |  |                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                   |                                                                                                                                            |  |                                                                                                                            |  |
| 22a. I certify that <del>the</del> (this hospital) attended the deceased from <i>12/10/81</i> to <i>9/18/82</i> , that <del>we</del> (we) last saw the deceased alive on <i>9/18/82</i> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above <del>the</del> (we) (did) (do not) view the body after death.              |  |                                                                                                                                                   |  |                                                                                                                                                             |                                                                          |                                                                                                 |                                                                                                   |                                                                                                                                            |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><i>JR Gladue MD</i>                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                   |  |                                                                                                                                                             |                                                                          | DEGREE<br><i>MD</i>                                                                             |                                                                                                   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>9/20/82</i>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Dr. J. R. Gladue</i>                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                   |  |                                                                                                                                                             |                                                                          | 22e. ADDRESS<br><i>MD John Deaton Medical Center</i>                                            |                                                                                                   |                                                                                                                                            |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Entombment</i>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                   |  | 23b. DATE<br><i>9/23/82</i>                                                                                                                                 |                                                                          | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Arbutus Memorial Pk.</i>                               |                                                                                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore County, Maryland</i>                                                            |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME <i>BALTO. MD.</i> ADDRESS <i>21210</i><br><i>Herbert F. Fawcett Funeral Home 505 W. North Ave.</i>                                                                                                                                                                                                                                                   |  |                                                                                                                                                   |  |                                                                                                                                                             |                                                                          | 25. DECEASED BY REGISTRAR                                                                       |                                                                                                   | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Conner</i>                                                                                        |  |                                                                                                                            |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                       |  | 8 2 2 3 6 0 3<br>REG. NO.                                                                                                                                |  |                                                                                                                         |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                       |  |                                                                                                                                                          |  |                                                                                                                         |                                              |
| I. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Dora Widgeon</b>                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>9 10 82</b>                                                                                                       |  | 2b. HOUR<br><b>M</b>                                                                                                    |                                              |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br><b>Black</b>                                                                                                               |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>5 2 12</b>                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>70 YRS.</b>                                                |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                            |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD</b>                                                       |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2806 Walbrook Avenue</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |                                              |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                       |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  | 13d. STREET ADDRESS<br><b>2806 Walbrook Avenue</b>                                                                      |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John Widgeon</b>                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                       |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Sarah Thomas</b>                                                                                        |  |                                                                                                                         |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.<br><b>216-34-8339</b>                                                                                                           |  | 17. INFORMANT ADDRESS<br><b>Francis Satchell 2806 Walbrook Avenue</b>                                                   |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory failure</b><br><b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of Breast with bone &amp; soft tissue metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>metastases</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                       |  |                                                                                                                                                          |  |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Cancer cachexia</b>                                                                                                                                                                                                                                                                                      |  |                                                                                                                                       |  |                                                                                                                                                          |  |                                                                                                                         |                                              |
| 19a. DATE OF OPERATION<br><b>-</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>                                                                          |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)                                                                           |  |                                                                                                                         |                                              |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                         |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/31/79</b> 19____, to <b>9/10/82</b> 19____ that (I) (we) last saw the deceased alive on <b>06/18/82</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                  |  |                                                                                                                                       |  |                                                                                                                                                          |  |                                                                                                                         |                                              |
| 22b. SIGNATURE<br><b>M.S. Didolkar</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                       |  | DEGREE<br><b>MD</b>                                                                                                                                      |  | 22c. DATE SIGNED<br><b>9/14/82</b>                                                                                      |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M.S. DIDOLKAR</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                       |  | 22e. ADDRESS<br><b>Univ. of Maryland Hospital Baltimore Md 21204</b>                                                                                     |  |                                                                                                                         |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br><b>9/15/82</b>                                                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Western Star Cem.</b>                                                                                           |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Md</b>                                                          |                                              |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm. C. March F/ H 1401 E. North Avenue</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                       |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 15 1982</b>                                                                                                      |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conish</b>                                                                     |                                              |

SEP 18 1965



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                              |  | REG. NO. 8 2 2 3 6 0 4                                                                                                                                   |  |                                                                                                                         |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ROSE HELEN WILKIE</b>                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                              |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>9 9 82</b>                                                                                                        |  |                                                                                                                         |                                              |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br><b>WHITE</b>                                                                                                                      |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>6 19 13</b>                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN<br><b>69</b> YRS.                |                                              |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PA</b>                                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.                                                                 |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>                                                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SBCA (So. Balto. Gen. Hosp)</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>teacher</b>                                                                          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>school</b>                                                                      |                                              |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                            |  | 13b. COUNTY<br><b>A. A. Co.</b>                                                                                                              |  | 13c. CITY OR TOWN<br><b>Brooklyn Hgts</b>                                                                                                                |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>TERRENCE MC DERMOTT</b>                                                                                                                                                                                                                                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>MARCELLA REISER</b>                                                                         |  | 16. SOCIAL SECURITY NO.<br><b>386-12-4208</b>                                                                                                            |  |                                                                                                                         |                                              |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR "NOT KNOWN")<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                 |  | 17b. SOCIAL SECURITY NO.<br><b>386-12-4208</b>                                                                                               |  | 17. INFORMANT ADDRESS<br><b>Rose A. Rager, 118 Berkshire Circle, East Longwood, Fla. 32750</b>                                                           |  |                                                                                                                         |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Failure</b><br>1830 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ovarian Carcinoma &amp; metastases</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Renal Failure, Sepsis</b> |  |                                                                                                                                              |  |                                                                                                                                                          |  |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>                                                                                                                                                                                                                                                                         |  |                                                                                                                                              |  |                                                                                                                                                          |  |                                                                                                                         |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                           |  |                                                                                                                         |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                          |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                         |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/7</b> 19 <b>82</b> , to <b>9/9</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>9/9</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                          |  |                                                                                                                                              |  |                                                                                                                                                          |  |                                                                                                                         |                                              |
| 22b. SIGNATURE<br><b>ZIGEL</b>                                                                                                                                                                                                                                                                                                                                                                                     |  | DEGREE<br><b>MD</b>                                                                                                                          |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED<br><b>9/9/82</b>                                                                                       |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ZIGEL</b>                                                                                                                                                                                                                                                                                                                                                              |  | 22e. ADDRESS<br><b>3001 S. HANOVER ST BALTO 2120</b>                                                                                         |  |                                                                                                                                                          |  |                                                                                                                         |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br><b>Sept. 12, 1982</b>                                                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cem.</b>                                                                                             |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Spangler, Pennsylvania</b>                                                |                                              |
| 24. FUNERAL DIRECTOR NAME<br><b>Geo. J. Gonce, 4001 Ritchie Hg., Baltimore, Md.</b>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 10 1982</b>                                                                                                      |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                                                     |                                              |





TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the deceased be received within 72 hours after death. Please return to the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed, filled in by the funeral director, and approved by the health officer, it should be delivered to the funeral director. Please note that the body should be buried within 72 hours after death.

TO THE STATE DEPT. OF HEALTH AND MEMORIAL HIGIENE prior to burial, cremation, or other disposition. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner is also required to submit

DHMH - 16 50M 1/81  
(VRA 15, 4)

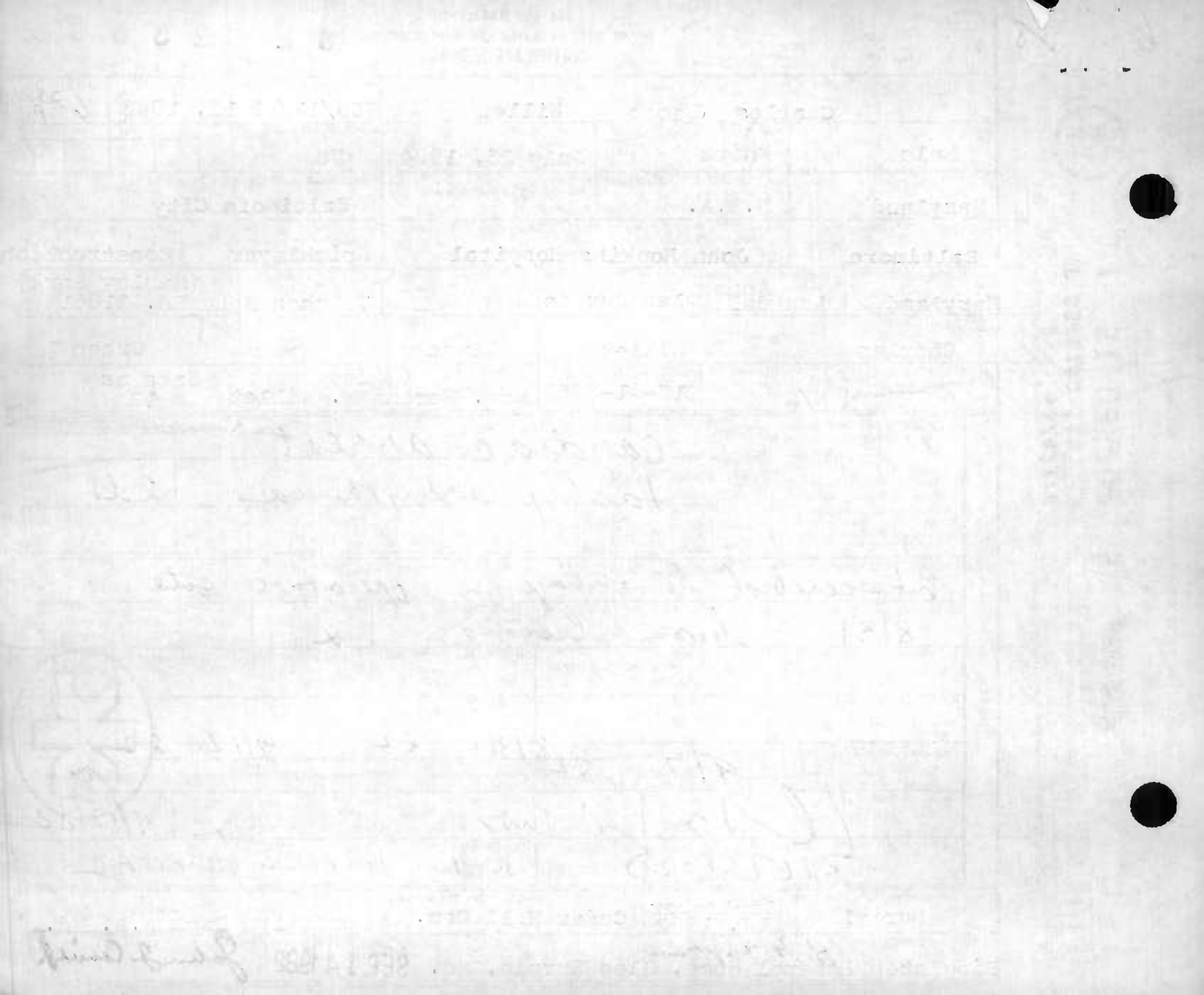
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 6 0 5

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                            |  |                                                                                                                                                             |  |                                                                |  |                             |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|--|-----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                          |  | FIRST MIDDLE LAST                                                                                                                                          |  | 2a. DATE OF DEATH                                                                                                                                           |  | MONTH DAY YEAR                                                 |  | 2b. HOUR                    |  |
| Charles Jacob Willet                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                            |  | September 12, 1982                                                                                                                                          |  | 6                                                              |  | 30 PM                       |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE                                                                                                                                                    |  | 5. DATE OF BIRTH                                                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  | 7. IF UNDER 1 YEAR          |  |
| Male                                                                                                                                                                                                                                                                                                                                                                         |  | White                                                                                                                                                      |  | July 26, 1904                                                                                                                                               |  | 78 YRS.                                                        |  | IF UNDER 24 HRS.            |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                                               |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |                             |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                     |  | U.S.A.                                                                                                                                                     |  |                                                                                                                                                             |  | Baltimore City MD.                                             |  |                             |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                                  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |                             |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                    |  | John Hopkins Hospital                                                                                                                                      |  | Bricklayer                                                                                                                                                  |  | Construction                                                   |  |                             |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                   |  | 13b. COUNTY                                                                                                                                                |  | 13c. CITY OR TOWN                                                                                                                                           |  | 13d. STREET ADDRESS                                            |  |                             |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                     |  | Anne Arundel                                                                                                                                               |  | Glen Burnie                                                                                                                                                 |  | 7 Queen Anne Rd. 21061 (Marley Park)                           |  |                             |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                            |  | 15. MOTHER'S MAIDEN NAME                                                                                                                                   |  |                                                                                                                                                             |  |                                                                |  |                             |  |
| Charles                                                                                                                                                                                                                                                                                                                                                                      |  | Blanche                                                                                                                                                    |  | Green                                                                                                                                                       |  |                                                                |  |                             |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                                                                                                                                                                                                                                                                                   |  | 16b. SOCIAL SECURITY NO.                                                                                                                                   |  | 17. INFORMANT (Wife) ADDRESS                                                                                                                                |  | 18. Same as # 13                                               |  |                             |  |
| No                                                                                                                                                                                                                                                                                                                                                                           |  | 215-01-6863                                                                                                                                                |  | Mrs. Bertha M. Willet                                                                                                                                       |  |                                                                |  |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>3488<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Tachy arrhythmia</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>2d</u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                               |  |                                                                                                                                                             |  |                                                                |  |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Intracerebral hemorrhage in operative site</u>                                                                                                                                                                                           |  |                                                                                                                                                            |  |                                                                                                                                                             |  |                                                                |  |                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                           |  | 20a. AUTOPSY?                                                                                                                                               |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                             |  |
| 8/31                                                                                                                                                                                                                                                                                                                                                                         |  | brain lesions                                                                                                                                              |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                         |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                |  |                             |  |
|                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                            |  |                                                                                                                                                             |  |                                                                |  |                             |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                     |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                |  |                             |  |
|                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                            |  |                                                                                                                                                             |  |                                                                |  |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/30</u> , 19 <u>82</u> , to <u>9/12</u> , 19 <u>82</u> , that (I) (we) lost<br>saw the deceased alive on <u>9/12</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did not attend the body after death.           |  |                                                                                                                                                            |  |                                                                                                                                                             |  |                                                                |  |                             |  |
| 22b. SIGNATURE<br><u>BRELSFORD</u>                                                                                                                                                                                                                                                                                                                                           |  | DEGREE<br>MD<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |                                                                                                                                                             |  |                                                                |  | 22c. DATE SIGNED<br>9/12/82 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                        |  | 22e. ADDRESS                                                                                                                                               |  |                                                                                                                                                             |  |                                                                |  |                             |  |
| BRELSFORD                                                                                                                                                                                                                                                                                                                                                                    |  | JOHNS HOPKINS HOSPITAL                                                                                                                                     |  |                                                                                                                                                             |  |                                                                |  |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE                                                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  | 23d. LOCATION                                                  |  |                             |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                       |  | September 16, 1982                                                                                                                                         |  | Cedar Hill Cem.                                                                                                                                             |  | Brooklyn Park A.A. Md.                                         |  |                             |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                    |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                              |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                                  |  |                                                                |  |                             |  |
| C. M. Hopkins                                                                                                                                                                                                                                                                                                                                                                |  | SEP 14 1982                                                                                                                                                |  | John J. Conner                                                                                                                                              |  |                                                                |  |                             |  |
| Singleton Funeral Home, Glen Burnie, Md.                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                            |  |                                                                                                                                                             |  |                                                                |  |                             |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                        |  |                                                                                                                                        |  |                                                                                                                                                             |                                                               |                                                                                                                                            |  |                                                           |  | 8 2 2 3 6 0 6 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------|--|---------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                |  | REG. NO.                                                                                                                               |  |                                                                                                                                                             |                                                               |                                                                                                                                            |  |                                                           |  |               |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>BOOKER T. WILLIAMS</b>                                                                                                                                                                                                                                                                                            |  |                                                                                                                                        |  |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9/13/82</b>         |                                                                                                                                            |  | 2b. HOUR<br><b>12:45</b> M                                |  |               |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br><b>Black</b>                                                                                                                |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12/20/13</b>                                                                                                       |                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.                                                                                          |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                 |  |               |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                             |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, City</b> MD.                                                                         |  |                                                           |  |               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT NURSING FACILITY, GIVE STREET ADDRESS)<br><b>Midtown Home, Inc.</b> |  |                                                                                                                                                             |                                                               | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY                         |  |               |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                     |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                        |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                                                               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                            |  | 13e. STREET ADDRESS<br><b>8 N. Gay St. (Edison Hotel)</b> |  |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>- - -</b>                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                        |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>- - -</b> |                                                                                                                                            |  |                                                           |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br><b>412-18-3958</b>                                                                                         |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Pearl Midtown Nursing Home</b>                                                                                          |                                                               |                                                                                                                                            |  |                                                           |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4/100</b> IMMEDIATE CAUSE (a) <b>ACUTE CORONARY THROMBOSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CORONARY PERIPHERAL VASCULAR DISEASE</b>                                   |  |                                                                                                                                        |  |                                                                                                                                                             |                                                               |                                                                                                                                            |  |                                                           |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>CORONARY PERIPHERAL VASCULAR DISEASE</b>                                                                                                                                                                             |  |                                                                                                                                        |  |                                                                                                                                                             |                                                               |                                                                                                                                            |  |                                                           |  |               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                                                               | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |  |                                                           |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                               |                                                                                                                                            |  |                                                           |  |               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                              |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                               |                                                                                                                                            |  |                                                           |  |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/13</b> 19 <b>82</b> , to <b>9/13</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>9/13</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death. |  |                                                                                                                                        |  |                                                                                                                                                             |                                                               |                                                                                                                                            |  |                                                           |  |               |  |
| 22b. SIGNATURE<br><b>Amurigue</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                        |  | DEGREE<br><b>MD</b>                                                                                                                                         |                                                               | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED                                          |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                        |  | 22e. ADDRESS                                                                                                                                                |                                                               |                                                                                                                                            |  |                                                           |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br><b>9/21/82</b>                                                                                                            |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Zion Cem</b>                                                                                                 |                                                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                                                                         |  |                                                           |  |               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. march F/H 1101 E. North Avenue</b>                                                                                                                                                                                                                                                                                |  |                                                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 23 1982</b>                                                                                                         |                                                               | 25b. REGISTRAR'S SIGNATURE<br><b>John J. ...</b>                                                                                           |  |                                                           |  |               |  |

|                   |                |                             |
|-------------------|----------------|-----------------------------|
| ROBERT T. HODGINS | WILLIAMS       | CHILDS                      |
| Male              | Black          | Black                       |
| Baltimore         | Baltimore, Md. | Baltimore, City             |
| MD                | Baltimore      | 8 N. Gay St. (Edison Hotel) |

412-18-2820

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TO FURNISH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 6 0 7

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EDWARD F WILLIAMS</b>                                                                                |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09 15 82</b>                                                                                                      |  | 2b. HOUR<br><b>2:15 PM</b>                                                                                                 |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br><b>Black</b>                                                                                                                     |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 13 07</b>                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS                                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 13b. COUNTY                                                                                                                                 |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Williams</b>                                                                                                                                                                                                                                                                                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lucy</b>                                                                                |  | 13e. STREET ADDRESS<br><b>5220 York Rd. Apt. 10E</b>                                                                                                        |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO.<br><b>227-03-9975</b>                                                                                              |  | 17. INFORMANT ADDRESS<br><b>Lillian Williams 5220 York Rd. Apt. 10E</b>                                                                                     |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory arrest</b><br><b>4289</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Cardiac failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 minutes</b> |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Renal Failure</b>                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                            |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>Sept 5</b> 19 <b>82</b> , to <b>Sept 15</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>Sept 14</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                            |  |                                                                                                                                             |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Michael Shear</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  | DEGREE<br><b>MD</b>                                                                                                                         |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>9/15/82</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael Shear</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  | 22e. ADDRESS<br><b>Union Memorial Hospital</b>                                                                                              |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br><b>9/20/82</b>                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>                                                                                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus Md.</b>                                                           |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/h 1101 E. North Avenue</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 17 1982</b>                                                                                                         |  |                                                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                                                                                         |  |                                                                                                                            |  |



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Items #18a-22a Film G572 10/26/82 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 2 3 6 0 8

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                                                          |  |                                                               |  |                                   |  |                                                                               |  |                          |  |                            |  |      |  |                                              |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|----------------------------------------------------------|--|---------------------------------------------------------------|--|-----------------------------------|--|-------------------------------------------------------------------------------|--|--------------------------|--|----------------------------|--|------|--|----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                      |         | FIRST                                                    |  | MIDDLE                                                        |  | LAST                              |  | 2a. DATE KNOWN OF DEATH                                                       |  | MONTH                    |  | DAY                        |  | YEAR |  | 2b. HOUR                                     |  |
| Elbert                                                                                                                                                                                                                                                                                                                                                                                                                                   |         | Williams                                                 |  |                                                               |  |                                   |  | 9                                                                             |  | 14                       |  | 1982                       |  |      |  | 8:33 a. M.                                   |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4. RACE | 5. DATE OF BIRTH                                         |  | 6. AGE (IN YEARS)                                             |  | IF UNDER 1 YR.                    |  | IF UNDER 24 HRS.                                                              |  | 7c. DATE PRONOUNCED DEAD |  | MONTH                      |  | DAY  |  | YEAR                                         |  |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                     | Black   | 4 13 52                                                  |  | 30 YRS.                                                       |  |                                   |  |                                                                               |  | 9                        |  | 14                         |  | 1982 |  |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                                |         | 7b. CITIZEN OF WHAT COUNTRY?                             |  | 8. MARRIED                                                    |  | NEVER MARRIED                     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                          |  |                          |  |                            |  |      |  |                                              |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                 |         | USA                                                      |  | WIDOWED                                                       |  | DIVORCED                          |  | Baltimore City,                                                               |  |                          |  |                            |  |      |  |                                              |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                                                                               |  |                          |  |                            |  |      |  |                                              |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                |         | Sinai Hospital                                           |  |                                                               |  |                                   |  |                                                                               |  |                          |  |                            |  |      |  |                                              |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                               |         | 13b. COUNTY                                              |  | 13c. CITY OR TOWN                                             |  | 13d. INSIDE CITY LIMITS?          |  | 13e. STREET ADDRESS                                                           |  |                          |  |                            |  |      |  |                                              |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                 |         |                                                          |  | Baltimore                                                     |  | YES XX NO                         |  | 5800 Rubin Avenue                                                             |  |                          |  |                            |  |      |  |                                              |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                        |         | 15. MOTHER'S MAIDEN NAME                                 |  |                                                               |  |                                   |  |                                                                               |  |                          |  |                            |  |      |  |                                              |  |
| Elbert                                                                                                                                                                                                                                                                                                                                                                                                                                   |         | L Williams Sr.                                           |  | Juanita                                                       |  | Thomas                            |  |                                                                               |  |                          |  |                            |  |      |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                                                                                                                                                                                                                                                                                                                                                                             |         | 16b. SOCIAL SECURITY NO.                                 |  | 17. INFORMANT                                                 |  | ADDRESS                           |  |                                                                               |  |                          |  |                            |  |      |  |                                              |  |
| No                                                                                                                                                                                                                                                                                                                                                                                                                                       |         | 217-56-3703                                              |  | Venice Williams                                               |  | 5800 Rubin Avenue                 |  |                                                                               |  |                          |  |                            |  |      |  |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                                |         |                                                          |  |                                                               |  |                                   |  |                                                                               |  |                          |  |                            |  |      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I DEATH WAS CAUSED BY: Cardiomegaly                                                                                                                                                                                                                                                                                                                                                                                                 |         |                                                          |  |                                                               |  |                                   |  |                                                                               |  |                          |  |                            |  |      |  |                                              |  |
| 4293 IMMEDIATE CAUSE (a)                                                                                                                                                                                                                                                                                                                                                                                                                 |         |                                                          |  |                                                               |  |                                   |  |                                                                               |  |                          |  |                            |  |      |  |                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                           |         |                                                          |  |                                                               |  |                                   |  |                                                                               |  |                          |  |                            |  |      |  |                                              |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                                                                                                                                                                                                                                                                                                                            |         |                                                          |  |                                                               |  |                                   |  |                                                                               |  |                          |  |                            |  |      |  |                                              |  |
| (b)                                                                                                                                                                                                                                                                                                                                                                                                                                      |         |                                                          |  |                                                               |  |                                   |  |                                                                               |  |                          |  |                            |  |      |  |                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                           |         |                                                          |  |                                                               |  |                                   |  |                                                                               |  |                          |  |                            |  |      |  |                                              |  |
| (c)                                                                                                                                                                                                                                                                                                                                                                                                                                      |         |                                                          |  |                                                               |  |                                   |  |                                                                               |  |                          |  |                            |  |      |  |                                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                                                                                                                                                                                                                                           |         |                                                          |  |                                                               |  |                                   |  |                                                                               |  |                          |  |                            |  |      |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |         |                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?             |  |                                   |  |                                                                               |  |                          |  | 20. AUTOPSY?               |  |      |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                                                          |  |                                                               |  |                                   |  |                                                                               |  |                          |  | YES XX NO                  |  |      |  |                                              |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                        |         |                                                          |  | 21b. TIME OF INJURY                                           |  |                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                          |  |                            |  |      |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                                                          |  | HOUR A.M. MONTH DAY YEAR                                      |  |                                   |  |                                                                               |  |                          |  |                            |  |      |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                                                          |  | P.M. 19                                                       |  |                                   |  |                                                                               |  |                          |  |                            |  |      |  |                                              |  |
| 21d. INJURY OCCURRED WHILE AT WORK                                                                                                                                                                                                                                                                                                                                                                                                       |         |                                                          |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |                                   |  | 21f. LOCATION                                                                 |  |                          |  |                            |  |      |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                                                          |  |                                                               |  |                                   |  | STREET CITY OR TOWN COUNTY STATE                                              |  |                          |  |                            |  |      |  |                                              |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |                                                          |  |                                                               |  |                                   |  |                                                                               |  |                          |  |                            |  |      |  |                                              |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                         |         |                                                          |  | TITLE (SPECIFY)                                               |  |                                   |  |                                                                               |  |                          |  | DATE SIGNED                |  |      |  |                                              |  |
| Margarita A. Korell, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                |         |                                                          |  | Assistant                                                     |  |                                   |  |                                                                               |  |                          |  | 9-14-82                    |  |      |  |                                              |  |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                          |         |                                                          |  | ADDRESS                                                       |  |                                   |  |                                                                               |  |                          |  |                            |  |      |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                                                          |  | 111 Penn Street                                               |  |                                   |  |                                                                               |  |                          |  |                            |  |      |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                |         |                                                          |  | 23b. DATE                                                     |  |                                   |  | 23c. NAME OF CEMETERY OR CREMATORY                                            |  |                          |  | 23d. LOCATION              |  |      |  |                                              |  |
| Entombment                                                                                                                                                                                                                                                                                                                                                                                                                               |         |                                                          |  | 9/18/82                                                       |  |                                   |  | Arbutus Memorial Pk.                                                          |  |                          |  | Arbutus Md.                |  |      |  |                                              |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                                                                                |         |                                                          |  | ADDRESS                                                       |  |                                   |  | 25a. DATE REC'D. BY REGISTRAR                                                 |  |                          |  | 25b. REGISTRAR'S SIGNATURE |  |      |  |                                              |  |
| Wm. C. March F/H 1101 E. North Avenue                                                                                                                                                                                                                                                                                                                                                                                                    |         |                                                          |  |                                                               |  |                                   |  | SEP 17 1982                                                                   |  |                          |  | John J. Lander             |  |      |  |                                              |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

WILSON

REBIL NO 100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3500

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                         |  | 8 2 2 3 6 0 9<br>REG. NO.                                                                                                                                   |  |                                                                                                                                |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Florence Williams</b>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                         |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>9 12 82</b>                                                                                                             |  |                                                                                                                                |  |
| 3 SEX <b>Female</b>                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                         |  | 2b. HOUR <b>9:24 PM</b>                                                                                                                                     |  |                                                                                                                                |  |
| 4 RACE <b>Black</b>                                                                                                                                                                                                                                                                                                                                                                       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>9 6 22</b>                                                                                        |  | 6. AGE (IN YEARS (LAST BIRTHDAY)) <b>60 YRS.</b>                                                                                                            |  |                                                                                                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                                 |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                                                                                |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>35 N. Catherine Street</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD                                                                                               |  |                                                                                                                                |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                         |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |  |                                                                                                                                |  |
| 13a. STATE <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                |  | 13b. COUNTY                                                                                                                             |  | 13c. CITY OR TOWN <b>Baltimore</b>                                                                                                                          |  | 13d. INSIDE CITY LIMITS? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>                            |  |
| 13e. STREET ADDRESS <b>35 N. Catherine Street</b>                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Joe Jones</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Edna Ross</b>                                                                                              |  |                                                                                                                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>                                                                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO. <b>N/A</b>                                                                                                     |  | 17. INFORMANT ADDRESS <b>Betty Kiah 35 N Catherine St</b>                                                                                                   |  |                                                                                                                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer of the Hard Palate</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>(Oropharynx)</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Neizure Disorder</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                                                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Diabetes mellitus</b>                                                                                                                                                                                                                                  |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                        |  | 20a. AUTOPSY? <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>                                                                    |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES <input type="checkbox"/> NO <input type="checkbox"/></b> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                                                                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19____, to 19____, that (I) (we) last saw the deceased on 19____, and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above, (I) (we) (did) (did not) view the body after death. <b>patient expired at home on 9/12/82</b>                                                    |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                                                |  |
| 22b. SIGNATURE <b>B. Gonzalez Jr</b>                                                                                                                                                                                                                                                                                                                                                      |  | 22c. DEGREE <b>MD</b>                                                                                                                   |  | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>             |  | 22e. DATE SIGNED <b>9/15/82</b>                                                                                                |  |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B. Gonzalez Jr</b>                                                                                                                                                                                                                                                                                                                               |  | 22g. ADDRESS <b>Bm Records HOSP - 2001 W. Fayette St Baltimore Md 21223</b>                                                             |  |                                                                                                                                                             |  |                                                                                                                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                   |  | 23b. DATE <b>9/17/82</b>                                                                                                                |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Eastview Mem. Pk.</b>                                                                                                 |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md</b>                                                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS <b>Wm. C. March F/Gh 1101 E. North Avenue</b>                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                         |  | 25a. DATE REC'D. BY REGISTRAR <b>SEP 17 1982</b>                                                                                                            |  |                                                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE <b>Jan J. Canich</b>                                                                                                             |  |                                                                                                                                |  |



9.9



Handwritten text, possibly a signature or a set of instructions, written in a cursive or script style.

Handwritten text at the bottom of the page, including what appears to be a date '10.10' and other illegible markings.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after discovery of a death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 6 1 0

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                 |                                                                                                                                                             |                                                                                      |                                                                                                                               |                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Dr. Joan of Arc, Williams                                                                                                                                                                                                                                                                                                        |                                                                                                                                 |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9-1-82                                        |                                                                                                                               | 2b. HOUR<br>6 A.M.                              |
| 3. SEX<br>female                                                                                                                                                                                                                                                                                                                                                        | 4. RACE<br>B                                                                                                                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9-6-12                                                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 yrs YRS.                                       |                                                                                                                               | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.       |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Illinois                                                                                                                                                                                                                                                                                                                | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |                                                                                                                               |                                                 |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |                                                                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY               |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                 |                                                                                                                                                             | 13b. CITY OR TOWN<br>Catonsville                                                     | 13c. STREET ADDRESS<br>701 Gun Road                                                                                           |                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jack Williams                                                                                                                                                                                                                                                                                                                 |                                                                                                                                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lucy Franklin Williams-                                                                                    |                                                                                      |                                                                                                                               |                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                                                                                                                                                                                                                                                      |                                                                                                                                 | 16b. SOCIAL SECURITY NO.<br>345-46-9026                                                                                                                     |                                                                                      | 17. INFORMANT<br>ADDRESS<br>Sister Marina 701 Gun Road                                                                        |                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>2773 IMMEDIATE CAUSE (a) <u>Serve cardiac failure.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>wide spread amyloidosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                               |                                                                                                                                 |                                                                                                                                                             |                                                                                      |                                                                                                                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>scleroderma, nephritic syndrome.</u>                                                                                                                                                                                                |                                                                                                                                 |                                                                                                                                                             |                                                                                      |                                                                                                                               |                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                                                      |                                                                                                                               |                                                 |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                      |                                                                                                                               |                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/21/82</u> , 19 <u>82</u> , to <u>9/1</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>8/23/82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                                                 |                                                                                                                                                             |                                                                                      |                                                                                                                               |                                                 |
| 22b. SIGNATURE<br>Purushottam Mitra                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                 | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                                                                      | 22c. DATE SIGNED<br>9/1/82                                                                                                    |                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MITRA, PURUSHOTTAM                                                                                                                                                                                                                                                                                                             |                                                                                                                                 | 22e. ADDRESS<br>St. Agnes Hospital                                                                                                                          |                                                                                      |                                                                                                                               |                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SEE CITY)<br>BURIAL                                                                                                                                                                                                                                                                                                                 | 23b. DATE<br>9/7/82                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cem                                                                                                     |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                                                                   |                                                 |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/ H 1101 E. North Avenue                                                                                                                                                                                                                                                                                                  |                                                                                                                                 | 25a. DATE REC'D BY REGISTRAR<br>SEP 3 1982                                                                                                                  |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel                                                                                  |                                                 |

57

U. S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

My dear Sir,  
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the application for a patent for the invention of a new and improved method of producing artificial silk.

I am sorry to hear that you have been unable to secure the necessary funds to carry out your invention. It is, however, my duty to inform you that the Department of Agriculture has no authority to grant financial assistance for the purpose of carrying out private inventions or experiments.

I am, Sir, very respectfully,  
Yours very truly,  
J. H. H. H.  
Director



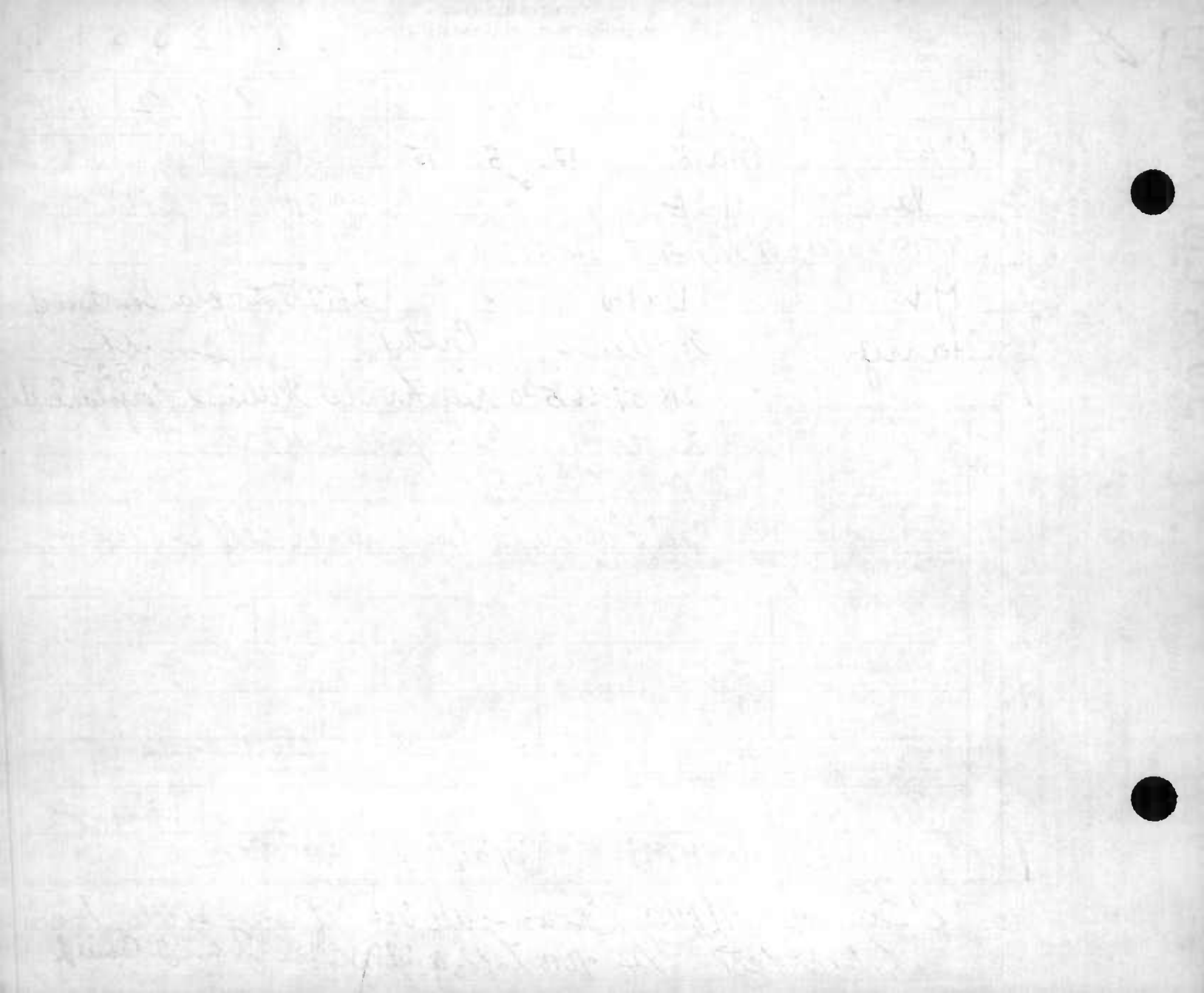
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified and a post-mortem examination should be performed.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                          |  |                              |  |                                                                                                                                                          |                                  |                                      |  |                                                                                |  | 8 2 2 3 6 1 1<br>REG. NO.                                      |  |                                   |  |  |          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--------------------------------------|--|--------------------------------------------------------------------------------|--|----------------------------------------------------------------|--|-----------------------------------|--|--|----------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                        |  |                              |  |                                                                                                                                                          | 1. DECEASED NAME (TYPE OR PRINT) |                                      |  |                                                                                |  | 2a. DATE OF DEATH MONTH DAY YEAR                               |  |                                   |  |  | 2b. HOUR |  |
|                                                                                                                                                                                                                                                                                                               |  |                              |  |                                                                                                                                                          | JOSEPH A. WILLIAMS               |                                      |  |                                                                                |  | 9 9 82                                                         |  |                                   |  |  | 1-10 PM  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                        |  | 4. RACE                      |  | 5. DATE OF BIRTH                                                                                                                                         |                                  | 6. AGE (IN YEARS LAST BIRTHDAY)      |  |                                                                                |  | IF UNDER 1 YEAR                                                |  | IF UNDER 24 HRS.                  |  |  |          |  |
| MALE                                                                                                                                                                                                                                                                                                          |  | Black                        |  | 12 5 15                                                                                                                                                  |                                  | 66 YRS.                              |  |                                                                                |  | MONTHS DAYS                                                    |  | HOURS MIN.                        |  |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                                                                                |  |                                                                |  |                                   |  |  |          |  |
| Va.                                                                                                                                                                                                                                                                                                           |  | USA                          |  |                                                                                                                                                          |                                  | BALTIMORE CITY MD.                   |  |                                                                                |  |                                                                |  |                                   |  |  |          |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                     |  |                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                                   |                                  |                                      |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  |                                                                |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |          |  |
| BALTIMORE CITY                                                                                                                                                                                                                                                                                                |  |                              |  | PROVIDENT HOSPITAL                                                                                                                                       |                                  |                                      |  |                                                                                |  |                                                                |  |                                   |  |  |          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                  |  |                              |  | 13b. COUNTY                                                                                                                                              |                                  | 13c. CITY OR TOWN                    |  | 13d. INSIDE CITY LIMITS?                                                       |  | 13e. STREET ADDRESS                                            |  |                                   |  |  |          |  |
| Md.                                                                                                                                                                                                                                                                                                           |  |                              |  |                                                                                                                                                          |                                  | Balto.                               |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 2525 Loyola Southway                                           |  |                                   |  |  |          |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)                                                                                                                                                                                                                                                                         |  |                              |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)                                                                                                             |                                  |                                      |  |                                                                                |  |                                                                |  |                                   |  |  |          |  |
| Harry                                                                                                                                                                                                                                                                                                         |  |                              |  | William                                                                                                                                                  |                                  | Betty                                |  |                                                                                |  | Smith                                                          |  |                                   |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                             |  |                              |  | 16b. SOCIAL SECURITY NO.                                                                                                                                 |                                  | 17. INFORMANT                        |  |                                                                                |  | ADDRESS                                                        |  |                                   |  |  |          |  |
|                                                                                                                                                                                                                                                                                                               |  |                              |  | 218-07-6695                                                                                                                                              |                                  | Carrie Frances Williams              |  |                                                                                |  | 2525 Loyola Southway                                           |  |                                   |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)                                                                                                                                                                                                                                      |  |                              |  |                                                                                                                                                          |                                  |                                      |  |                                                                                |  |                                                                |  |                                   |  |  |          |  |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                  |  |                              |  |                                                                                                                                                          |                                  |                                      |  |                                                                                |  |                                                                |  |                                   |  |  |          |  |
| IMMEDIATE CAUSE (a) Cardio Respiratory arrest                                                                                                                                                                                                                                                                 |  |                              |  |                                                                                                                                                          |                                  |                                      |  |                                                                                |  |                                                                |  |                                   |  |  |          |  |
| 1890                                                                                                                                                                                                                                                                                                          |  |                              |  |                                                                                                                                                          |                                  |                                      |  |                                                                                |  |                                                                |  |                                   |  |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure                                                                                                                                                                                                                                                              |  |                              |  |                                                                                                                                                          |                                  |                                      |  |                                                                                |  |                                                                |  |                                   |  |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Probable Metastatic Renal cell carcinoma                                                                                                                                                                                                                                   |  |                              |  |                                                                                                                                                          |                                  |                                      |  |                                                                                |  |                                                                |  |                                   |  |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                              |  |                              |  |                                                                                                                                                          |                                  |                                      |  |                                                                                |  |                                                                |  |                                   |  |  |          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                        |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                  |                                      |  | 20a. AUTOPSY?                                                                  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                                   |  |  |          |  |
|                                                                                                                                                                                                                                                                                                               |  |                              |  |                                                                                                                                                          |                                  |                                      |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                                   |  |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                            |  |                              |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.                                                                                                        |                                  |                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |                                                                |  |                                   |  |  |          |  |
|                                                                                                                                                                                                                                                                                                               |  |                              |  |                                                                                                                                                          |                                  |                                      |  |                                                                                |  |                                                                |  |                                   |  |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>                                                                                                                                                  |  |                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                  |                                      |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |                                                                |  |                                   |  |  |          |  |
|                                                                                                                                                                                                                                                                                                               |  |                              |  |                                                                                                                                                          |                                  |                                      |  |                                                                                |  |                                                                |  |                                   |  |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/20, 1982, to 9-9, 1982, that (I) (we) last saw the deceased alive on 9-9, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |  |                                                                                                                                                          |                                  |                                      |  |                                                                                |  |                                                                |  |                                   |  |  |          |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                |  |                              |  | DEGREE                                                                                                                                                   |                                  |                                      |  | 22c. DATE SIGNED                                                               |  |                                                                |  |                                   |  |  |          |  |
| SHER AFZAL HASHMI                                                                                                                                                                                                                                                                                             |  |                              |  | MD                                                                                                                                                       |                                  |                                      |  | 9-9-82                                                                         |  |                                                                |  |                                   |  |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                         |  |                              |  | 22e. ADDRESS                                                                                                                                             |                                  |                                      |  |                                                                                |  |                                                                |  |                                   |  |  |          |  |
| SHER AFZAL HASHMI                                                                                                                                                                                                                                                                                             |  |                              |  | PROVIDENT HOSPITAL                                                                                                                                       |                                  |                                      |  |                                                                                |  |                                                                |  |                                   |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                     |  |                              |  | 23b. DATE                                                                                                                                                |                                  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                        |  |                                                                |  |                                   |  |  |          |  |
| Burial                                                                                                                                                                                                                                                                                                        |  |                              |  | 9/14/82                                                                                                                                                  |                                  | Crownsville, Md.                     |  | Crownsville, Md.                                                               |  |                                                                |  |                                   |  |  |          |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                     |  |                              |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |                                  |                                      |  | REGISTRAR'S SIGNATURE                                                          |  |                                                                |  |                                   |  |  |          |  |
| L. O. Nyell                                                                                                                                                                                                                                                                                                   |  |                              |  | 7/6                                                                                                                                                      |                                  |                                      |  | SEP 15 1982 John J. Carver                                                     |  |                                                                |  |                                   |  |  |          |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                            |         |                                                                                                            |  |                                                                                       |  |                                                                                                 |  |                                                                                     |  |                                                                                                      |  |          |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                        |         | FIRST                                                                                                      |  | MIDDLE                                                                                |  | LAST                                                                                            |  | 2a. DATE KNOWN<br>OF DEATH                                                          |  | <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR |  | 2b. HOUR |  |
| LAKEYA                                                                                                                                                                                                                                                                                                                                                                                                                                     |         |                                                                                                            |  |                                                                                       |  | WILLIAMS                                                                                        |  | 9 3 19 82                                                                           |  |                                                                                                      |  | 4:30     |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                     | 4. RACE | 5. DATE OF BIRTH                                                                                           |  | 6. AGE (IN YEARS)                                                                     |  | IF UNDER 1 YR.                                                                                  |  | IF UNDER 24 HRS.                                                                    |  | 2c. DATE<br>PRONOUNCED<br>DEAD                                                                       |  | 2d. HOUR |  |
| Female                                                                                                                                                                                                                                                                                                                                                                                                                                     | Black   | 1 28 82                                                                                                    |  | LAST BIRTHDAY<br>YRS.                                                                 |  | MONTHS 7                                                                                        |  | DAYS                                                                                |  | 9 3 19 82                                                                                            |  | 4:30     |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                               |         | 7b. CITIZEN OF WHAT COUNTRY?                                                                               |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                              |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                |  |                                                                                                      |  |          |  |
| Washington D.C.                                                                                                                                                                                                                                                                                                                                                                                                                            |         | USA                                                                                                        |  |                                                                                       |  |                                                                                                 |  | Baltimore City                                                                      |  |                                                                                                      |  |          |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                      |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                                            |  |                                                                                     |  |                                                                                                      |  |          |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                  |         | Johns Hopkins Hospital                                                                                     |  |                                                                                       |  |                                                                                                 |  |                                                                                     |  |                                                                                                      |  |          |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                                                                 |         | 13b. COUNTY                                                                                                |  | 13c. CITY OR TOWN                                                                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS                                                                 |  |                                                                                                      |  |          |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                   |         |                                                                                                            |  | Baltimore                                                                             |  |                                                                                                 |  | 3969 Sinclair Lane                                                                  |  |                                                                                                      |  |          |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                          |         | 15. MOTHER'S MAIDEN NAME                                                                                   |  |                                                                                       |  |                                                                                                 |  |                                                                                     |  |                                                                                                      |  |          |  |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                                          |         | FIRST MIDDLE LAST                                                                                          |  |                                                                                       |  |                                                                                                 |  |                                                                                     |  |                                                                                                      |  |          |  |
| Gilbert R. Cotton                                                                                                                                                                                                                                                                                                                                                                                                                          |         | Carolyn Williams                                                                                           |  |                                                                                       |  |                                                                                                 |  |                                                                                     |  |                                                                                                      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                      |         | 16b. SOCIAL SECURITY NO.                                                                                   |  | 17. INFORMANT                                                                         |  | ADDRESS                                                                                         |  |                                                                                     |  |                                                                                                      |  |          |  |
| No                                                                                                                                                                                                                                                                                                                                                                                                                                         |         | N/A                                                                                                        |  | Carolyn Williams                                                                      |  | 3969 Sinclair Lane                                                                              |  |                                                                                     |  |                                                                                                      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>7999 IMMEDIATE CAUSE (a) Cranio-cerebral trauma<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                   |         |                                                                                                            |  |                                                                                       |  |                                                                                                 |  |                                                                                     |  |                                                                                                      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                        |         |                                                                                                            |  |                                                                                       |  |                                                                                                 |  |                                                                                     |  |                                                                                                      |  |          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                     |         |                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                     |  |                                                                                                 |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                                                                                      |  |          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                       |         |                                                                                                            |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. ? 19                          |  |                                                                                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>?  |  |                                                                                                      |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                             |         |                                                                                                            |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>?                   |  |                                                                                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>? ? ? ? ?                      |  |                                                                                                      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . |         |                                                                                                            |  |                                                                                       |  |                                                                                                 |  |                                                                                     |  |                                                                                                      |  |          |  |
| ACTUAL<br>SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                        |         |                                                                                                            |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER                                    |  |                                                                                                 |  | DATE<br>SIGNED 9-4-82                                                               |  |                                                                                                      |  |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                         |         |                                                                                                            |  | ADDRESS                                                                               |  |                                                                                                 |  |                                                                                     |  |                                                                                                      |  |          |  |
| Ann M. Dixon, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                         |         |                                                                                                            |  | 111 Penn St., Balto., Md. 21201                                                       |  |                                                                                                 |  |                                                                                     |  |                                                                                                      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                               |         |                                                                                                            |  | 23b. DATE                                                                             |  |                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY                                                  |  |                                                                                                      |  |          |  |
| BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                     |         |                                                                                                            |  | 9/10/82                                                                               |  |                                                                                                 |  | Md. Veteran cem                                                                     |  |                                                                                                      |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                                                                                               |         |                                                                                                            |  | 25a. DATE REC'D. BY REGISTRAR                                                         |  |                                                                                                 |  | 25b. REGISTRAR'S SIGNATURE                                                          |  |                                                                                                      |  |          |  |
| Wm. C. March F/H 1101 E. North Avenue                                                                                                                                                                                                                                                                                                                                                                                                      |         |                                                                                                            |  | SEP 10 1982                                                                           |  |                                                                                                 |  | John J. Connel                                                                      |  |                                                                                                      |  |          |  |
| 23d. LOCATION<br>CITY OR TOWN                                                                                                                                                                                                                                                                                                                                                                                                              |         |                                                                                                            |  | COUNTY                                                                                |  |                                                                                                 |  | STATE                                                                               |  |                                                                                                      |  |          |  |
| Crownsville                                                                                                                                                                                                                                                                                                                                                                                                                                |         |                                                                                                            |  |                                                                                       |  |                                                                                                 |  | Md.                                                                                 |  |                                                                                                      |  |          |  |

BP

938171 NO TIO

NOV 19 1964



V-6-51

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                 |  |               |  |                                                                                                                               |  |                                                        |  |                                                                                                                                                          |  |                                |  | REG. NO. 2 3 6 1 3                                                                                                                 |  |                             |  |                                                                                              |  |                                  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------|--|----------------------------------------------------------------------------------------------|--|----------------------------------|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                  |  |               |  |                                                                                                                               |  |                                                        |  |                                                                                                                                                          |  |                                |  | 2a. DATE KNOWN OF DEATH                                                                                                            |  | 2b. HOUR                    |  |                                                                                              |  |                                  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MAURICE MIDDLE WILLIAMS LAST                                                                                                                                                                                                                                                                                                     |  |               |  |                                                                                                                               |  |                                                        |  |                                                                                                                                                          |  |                                |  | MONTH DAY YEAR 9 21 1982                                                                                                           |  | M 8:35                      |  |                                                                                              |  |                                  |  |
| 3. SEX Male                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE Black |  | 5. DATE OF BIRTH MONTH DAY YEAR 12 9 60                                                                                       |  | 6. AGE (IN YEARS LAST BIRTHDAY) 22 YRS.                |  | 7. IF UNDER 1 YR. MONTHS DAYS                                                                                                                            |  | 7. IF UNDER 24 HRS. HOURS MIN. |  | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 21 1982                                                                                  |  | 2d. HOUR P M                |  |                                                                                              |  |                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland                                                                                                                                                                                                                                                                                                                      |  |               |  | 7b. CITIZEN OF WHAT COUNTRY? USA                                                                                              |  |                                                        |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.                                                                            |  |                             |  |                                                                                              |  |                                  |  |
| 10. CITY OR TOWN OF DEATH Baltimore                                                                                                                                                                                                                                                                                                                                     |  |               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7100 blk. Supply Ave. |  |                                                        |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  |                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                  |  |                             |  |                                                                                              |  |                                  |  |
| 13a. STATE Maryland                                                                                                                                                                                                                                                                                                                                                     |  |               |  |                                                                                                                               |  |                                                        |  |                                                                                                                                                          |  |                                |  | 13b. COUNTY                                                                                                                        |  | 13c. CITY OR TOWN Baltimore |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS 7217 Jimrowe |  |
| 14. FATHER'S NAME FIRST Robert MIDDLE L. LAST Williams                                                                                                                                                                                                                                                                                                                  |  |               |  |                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME FIRST Essie MIDDLE Davis LAST |  |                                                                                                                                                          |  |                                |  |                                                                                                                                    |  |                             |  |                                                                                              |  |                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No                                                                                                                                                                                                                                                                                                   |  |               |  | 16b. SOCIAL SECURITY NO. 215-78-7826                                                                                          |  |                                                        |  | 17. INFORMANT ADDRESS Essie Williams 7217 Jimrowe                                                                                                        |  |                                |  |                                                                                                                                    |  |                             |  |                                                                                              |  |                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 9660 Stab wound of chest involving heart<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. |  |               |  |                                                                                                                               |  |                                                        |  |                                                                                                                                                          |  |                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                       |  |                             |  |                                                                                              |  |                                  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                      |  |               |  |                                                                                                                               |  |                                                        |  |                                                                                                                                                          |  |                                |  |                                                                                                                                    |  |                             |  |                                                                                              |  |                                  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                  |  |               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                             |  |                                                        |  |                                                                                                                                                          |  |                                |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                   |  |                             |  |                                                                                              |  |                                  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                          |  |               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 9-21- 1982                                                                |  |                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject stabbed.                                                           |  |                                |  |                                                                                                                                    |  |                             |  |                                                                                              |  |                                  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                       |  |               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Lot                                                               |  |                                                        |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 7100 blk. Supply Ave., Balto. City Md.                                                                    |  |                                |  |                                                                                                                                    |  |                             |  |                                                                                              |  |                                  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>                                                                     |  |               |  |                                                                                                                               |  |                                                        |  |                                                                                                                                                          |  |                                |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                             |  |                                                                                              |  |                                  |  |
| ACTUAL SIGNATURE [Signature]                                                                                                                                                                                                                                                                                                                                            |  |               |  | TITLE (SPECIFY) M.D. Assistant                                                                                                |  |                                                        |  | DATE SIGNED 9-22-82                                                                                                                                      |  |                                |  | MEDICAL EXAMINER                                                                                                                   |  |                             |  |                                                                                              |  |                                  |  |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.                                                                                                                                                                                                                                                                                                                      |  |               |  | ADDRESS 111 Penn St., Balto., Md. 21201                                                                                       |  |                                                        |  |                                                                                                                                                          |  |                                |  |                                                                                                                                    |  |                             |  |                                                                                              |  |                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL                                                                                                                                                                                                                                                                                                                        |  |               |  | 23b. DATE 9/25/82                                                                                                             |  |                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery                                                                                                   |  |                                |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.                                                                              |  |                             |  |                                                                                              |  |                                  |  |
| 24. FUNERAL DIRECTOR NAME Wm. C. March                                                                                                                                                                                                                                                                                                                                  |  |               |  | ADDRESS F/H 1101 E. North Avenue                                                                                              |  |                                                        |  | 25a. DATE REC'D. BY REGISTRAR SEP 23 1982                                                                                                                |  |                                |  | 25b. REGISTRAR'S SIGNATURE [Signature]                                                                                             |  |                             |  |                                                                                              |  |                                  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 6 1 4  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|--------------------------------------------------------------------------------|-----------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                         |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                               | 2b. HOUR                                                                       |                                   |
| I. DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                               |                                                                                                        | MONTH DAY YEAR                                                                                                                                           |                                                               | MONTHS DAYS HOURS MIN.                                                         |                                   |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                              |                                                                                                        | 9 29 82                                                                                                                                                  |                                                               | 2:10 P M                                                                       |                                   |
| ROBERT F. WILLIAMS                                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
| 3. SEX                                                                                                                                                                                                                                                                                                                         | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)                               | IF UNDER 1 YEAR IF UNDER 24 HRS                                                |                                   |
| Male                                                                                                                                                                                                                                                                                                                           | Black                                                                                                  | MONTH DAY YEAR                                                                                                                                           | 71 YRS.                                                       |                                                                                |                                   |
|                                                                                                                                                                                                                                                                                                                                |                                                                                                        | 08 14 71                                                                                                                                                 |                                                               |                                                                                |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                      | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |                                                                                |                                   |
| S. Carolina                                                                                                                                                                                                                                                                                                                    | USA                                                                                                    |                                                                                                                                                          | BALTIMORE CITY MD.                                            |                                                                                |                                   |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY |
| BALTIMORE                                                                                                                                                                                                                                                                                                                      | VAMC LOCH RAVEN BLVD. BALTO. MD                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
| 13a. STATE                                                                                                                                                                                                                                                                                                                     |                                                                                                        | 13b. COUNTY                                                                                                                                              | 13c. CITY OR TOWN                                             | 13d. INSIDE CITY LIMITS?                                                       |                                   |
| Md.                                                                                                                                                                                                                                                                                                                            |                                                                                                        |                                                                                                                                                          | Baltimore                                                     | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                   |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                              |                                                                                                        | 15. MOTHER'S MAIDEN NAME                                                                                                                                 |                                                               | 13e. STREET ADDRESS                                                            |                                   |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                              |                                                                                                        | FIRST MIDDLE LAST                                                                                                                                        |                                                               | VA Hosp. Loch Raven Blvd.                                                      |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                                                                                                                                                                                                                                  |                                                                                                        | 16b. SOCIAL SECURITY NO.                                                                                                                                 | 17. INFORMANT ADDRESS                                         |                                                                                |                                   |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/> WW II                                                                                                                                                                                                                     |                                                                                                        | 717 12 9473                                                                                                                                              | Louvenia Brantley 1538 Sheffield Rd.                          |                                                                                |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                      |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
| IMMEDIATE CAUSE (a) Sepsis and Cardiorespiratory Arrest                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
| 5860 DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                            |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
| (b) Renal Failure                                                                                                                                                                                                                                                                                                              |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
| (c) Evisceration.                                                                                                                                                                                                                                                                                                              |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no                                                                                                                                                                                            |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                         |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                               | 20a. AUTOPSY?                                                                  |                                   |
|                                                                                                                                                                                                                                                                                                                                |                                                                                                        |                                                                                                                                                          |                                                               | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                             |                                                                                                        | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                                                                             |                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) |                                   |
|                                                                                                                                                                                                                                                                                                                                |                                                                                                        | P.M. 19                                                                                                                                                  |                                                               |                                                                                |                                   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                       |                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                               | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                                   |
|                                                                                                                                                                                                                                                                                                                                |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
| 22a. I certify that (X) (this hospital) attended the deceased from August 7, 1982, to September 29, 1982, that (X) (we) lost the deceased alive on September 29, 1982, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. |                                                                                                        |                                                                                                                                                          |                                                               |                                                                                |                                   |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                 |                                                                                                        | DEGREE                                                                                                                                                   |                                                               | 22c. DATE SIGNED                                                               |                                   |
| Bruce Moffatt MD                                                                                                                                                                                                                                                                                                               |                                                                                                        |                                                                                                                                                          |                                                               | 9/30/82                                                                        |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                          |                                                                                                        | 22e. ADDRESS                                                                                                                                             |                                                               |                                                                                |                                   |
| Bruce Moffatt                                                                                                                                                                                                                                                                                                                  |                                                                                                        | 3900 Loch Raven Blvd. Balto. Md 21218                                                                                                                    |                                                               |                                                                                |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                      |                                                                                                        | 23b. DATE                                                                                                                                                | 23c. NAME OF CEMETERY OR CREMATORY                            | 23d. LOCATION CITY OR TOWN COUNTY STATE                                        |                                   |
| Burial                                                                                                                                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                          | Crownsville                                                   |                                                                                |                                   |
| 24. FUNERAL DIRECTOR NAME ADDRESS                                                                                                                                                                                                                                                                                              |                                                                                                        |                                                                                                                                                          | 25a. DATE REC'D. BY REGISTRAR                                 |                                                                                |                                   |
| Leroy O. Dyett 4600 Liberty Heights Ave.                                                                                                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                          | OCT 1 1982                                                    |                                                                                |                                   |
|                                                                                                                                                                                                                                                                                                                                |                                                                                                        |                                                                                                                                                          | 25b. REGISTRAR'S SIGNATURE                                    |                                                                                |                                   |
|                                                                                                                                                                                                                                                                                                                                |                                                                                                        |                                                                                                                                                          | John J. Connelley                                             |                                                                                |                                   |

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Report on the  
Kendall Farm  
Survey of 1910

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a necropsy performed.

| FOR<br>1. STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                         |                                                                                                                                                | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                        |                                                                                                 | 8 2 2 3 6 1 5<br>REG. NO.                                                                                                                  |                                                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>VIVIAN WILLIAMS</b>                                                                                                                                                                                                                                                   |                                                                                                                                                |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09 07 82</b>                                          |                                                                                                                                            | 2b. HOUR<br><b>8:15 AM</b>                                                                                                    |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                   | 4. RACE<br><b>N</b>                                                                                                                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>07 22 04</b>                                                                                                       |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.                                                                                          | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>SC</b>                                                                                                                                                                                                                                                                               | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD.                                                                          |                                                                                                                               |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South BALTIMORE GEN. HOSP.</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NONE</b>                 |                                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>NONE</b>                                                                              |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                        | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>3320 FAIRFIELD RD BALTIMORE, MD 21226</b>                                                                        |                                                                                                                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOSEPH BLACK</b>                                                                                                                                                                                                                                                                        |                                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>EMMA VINCENTI</b>                                                                                       |                                                                                                 |                                                                                                                                            |                                                                                                                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                    |                                                                                                                                                | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>                                                                                                                      |                                                                                                 | 17. INFORMANT<br><b>Ernest Williams</b> ADDRESS<br><b>3320 Fairfield Rd-</b>                                                               |                                                                                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). <b>CARDIORESPIRATORY ARREST</b><br><b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b). <b>CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c). <b>METASTATIC BREAST CANCER</b> |                                                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                                                                            | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                  |                                                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                                                                            |                                                                                                                               |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                               |                                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                             |                                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                            |                                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-8-82</b> to <b>8-7-82</b> , that (I) (we) last saw the deceased alive on <b>8-7-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.            |                                                                                                                                                |                                                                                                                                                             |                                                                                                 |                                                                                                                                            |                                                                                                                               |
| 22b. SIGNATURE<br><b>M. Sharp</b>                                                                                                                                                                                                                                                                                                    |                                                                                                                                                | DEGREE                                                                                                                                                      |                                                                                                 | 22c. DATE SIGNED<br><b>8/7/82</b>                                                                                                          |                                                                                                                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Sharp</b>                                                                                                                                                                                                                                                                                |                                                                                                                                                | 22e. ADDRESS                                                                                                                                                |                                                                                                 | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                                               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                        |                                                                                                                                                | 23b. DATE<br><b>9/11/82</b>                                                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Calvary Cem</b>                                  |                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md</b>                                                             |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/J 1101 E. North Avenue</b>                                                                                                                                                                                                                                                         |                                                                                                                                                |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 15 1982</b>                                             |                                                                                                                                            |                                                                                                                               |
|                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                |                                                                                                                                                             | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                             |                                                                                                                                            |                                                                                                                               |



METROPHILUS DENTATUS

SEP 15 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be called to see the body.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    |                                                        | REG. NO. 8 2 2 3 6 1 6                                                                                                                                      |                           |                                                                                                                            |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                    |                                                        |                                                                                                                                                             |                           |                                                                                                                            |                                              |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>CLARA L. WILLIAMSON                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                    | 2a. DATE OF DEATH MONTH DAY YEAR<br>SEPTEMBER 15, 1982 |                                                                                                                                                             | 2b. HOUR AM PM<br>8:16 AM |                                                                                                                            |                                              |
| 3 SEX<br>Female                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br>Black                                                                                                                   |                                                        | 5. DATE OF BIRTH MONTH DAY YEAR<br>6 8 99                                                                                                                   |                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS                                                                                  |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N. Carolina                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                |                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                 |                                              |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Home and Hospital |                                                        | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                               |                           | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                              |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                    |                                                        | 13b. COUNTY                                                                                                                                                 |                           | 13c. CITY OR TOWN<br>Baltimore                                                                                             |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Frank Mitchell                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                    |                                                        | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Amy                                                                                                           |                           |                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.<br>239-16-8205                                                                                            |                                                        | 17. INFORMANT ADDRESS<br>Allen A. Clinton 3311 Egin Avenue                                                                                                  |                           |                                                                                                                            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 0389 NATURAL DEATH (NO SPECIAL CAUSE)<br>DUE TO, OR AS A CONSEQUENCE OF (b) QUESTIONABLE SEPTICEMIA<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |                                                                                                                                    |                                                        |                                                                                                                                                             |                           |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                          |  |                                                                                                                                    |                                                        |                                                                                                                                                             |                           |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |                                                        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                            |                                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                           |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |                                                        | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |                           |                                                                                                                            |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from AUGUST 20, 19 82, to SEPTEMBER 15, 19 82, that (I) (we) last saw the deceased alive on SEPTEMBER 15, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.                                        |  |                                                                                                                                    |                                                        |                                                                                                                                                             |                           |                                                                                                                            |                                              |
| 22b. SIGNATURE<br>A. Nazemi M.D.                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                    |                                                        | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                           | 22c. DATE SIGNED<br>9/15/82                                                                                                |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. NAZEMI, M.D.                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                    |                                                        | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION<br>100 NORTH BROADWAY, BALTIMORE, MD 21231                                                                      |                           |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br>9/20/82                                                                                                               |                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery                                                                                                    |                           | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Md.                                                                   |                                              |
| 24. FUNERAL DIRECTOR NAME<br>Wm. C. March F/H 1101 E. North Avenue                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                    |                                                        | 25a. DATE RECD. BY REGISTRAR<br>SEP 21 1982                                                                                                                 |                           | 25b. REGISTRAR'S SIGNATURE<br>John J. Carver                                                                               |                                              |

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY



SEP 21 1932

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                  |  |                                                                                                                                                              |                                 |                                                                                              |                                                           |                                                                              |  | 8 2 2 3 6 1 7<br>REG. NO.                                                                                               |                                   |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|----------------------------------------------------------------------------------------------|-----------------------------------------------------------|------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ADA</b>                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                  |  |                                                                                                                                                              | FIRST MIDDLE LAST <b>WILSON</b> |                                                                                              |                                                           | 2a. DATE OF DEATH MONTH DAY YEAR <b>9 14 82</b>                              |  |                                                                                                                         | 2b. HOUR <b>5<sup>40</sup> AM</b> |  |
| 3. SEX <b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE <b>Black</b>                                                                                                             |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>1 20 1904</b>                                                                                                             |                                 |                                                                                              | 6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS             |                                                                              |  | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.                                                                                  |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>                                                                                         |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>     |                                 |                                                                                              | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD. |                                                                              |  |                                                                                                                         |                                   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>President Hospital</b> |  |                                                                                                                                                              |                                 |                                                                                              |                                                           | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |                                   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md</b>                                                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY <b>Balto.</b>                                                                                                        |  | 13c. CITY OR TOWN <b>Balto.</b>                                                                                                                              |                                 | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                           | 13e. STREET ADDRESS <b>4231 Roland View Ave</b>                              |  |                                                                                                                         |                                   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Wells</b>                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ADA BARNETT</b>                                                                                                |                                 |                                                                                              |                                                           |                                                                              |  |                                                                                                                         |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                  |  | 16b. SOCIAL SECURITY NO. <b>212-56-6018</b>                                                                                                                  |                                 | 17. INFORMANT ADDRESS <b>Medical Records</b>                                                 |                                                           |                                                                              |  |                                                                                                                         |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-pulmonary arrest</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Respiratory Failure and Metabolic Acidosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Anticoagulant Myocardial Infarction</b> |  |                                                                                                                                  |  |                                                                                                                                                              |                                 |                                                                                              |                                                           |                                                                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                            |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c)                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                  |  |                                                                                                                                                              |                                 |                                                                                              |                                                           |                                                                              |  |                                                                                                                         |                                   |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                             |                                 |                                                                                              |                                                           | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>                                                                                                  |                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)               |                                                           |                                                                              |  |                                                                                                                         |                                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                          |                                 | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                               |                                                           |                                                                              |  |                                                                                                                         |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                                                                            |  |                                                                                                                                  |  |                                                                                                                                                              |                                 |                                                                                              |                                                           |                                                                              |  |                                                                                                                         |                                   |  |
| 22b. SIGNATURE <b>Sandra L. Howard</b>                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                  |  | DEGREE <b>MD.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                 |                                                                                              |                                                           | 22c. DATE SIGNED <b>9-14-82</b>                                              |  |                                                                                                                         |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Sandra L. Howard</b>                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                  |  | 22e. ADDRESS <b>2000 Liberty Hgts 21215</b>                                                                                                                  |                                 |                                                                                              |                                                           |                                                                              |  |                                                                                                                         |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  | 23b. DATE <b>9-17-82</b>                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Mt Calvary Cem</b>                                                                                                     |                                 | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>A.A.C. Md</b>                                     |                                                           |                                                                              |  |                                                                                                                         |                                   |  |
| 24. FUNERAL DIRECTOR NAME <b>BROWN-Thompson F.H.</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                  |  | ADDRESS <b>1913 W. Balto. St.</b>                                                                                                                            |                                 |                                                                                              |                                                           | 25a. DATE REC'D. BY REGISTRAR <b>SEP 17 1982</b>                             |  |                                                                                                                         |                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                  |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Carney</b>                                                                                                             |                                 |                                                                                              |                                                           |                                                                              |  |                                                                                                                         |                                   |  |



INDICATED

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Large block of handwritten text in the middle of the page, mostly illegible due to fading and bleed-through.

Handwritten text at the bottom of the page, mostly illegible due to fading and bleed-through.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

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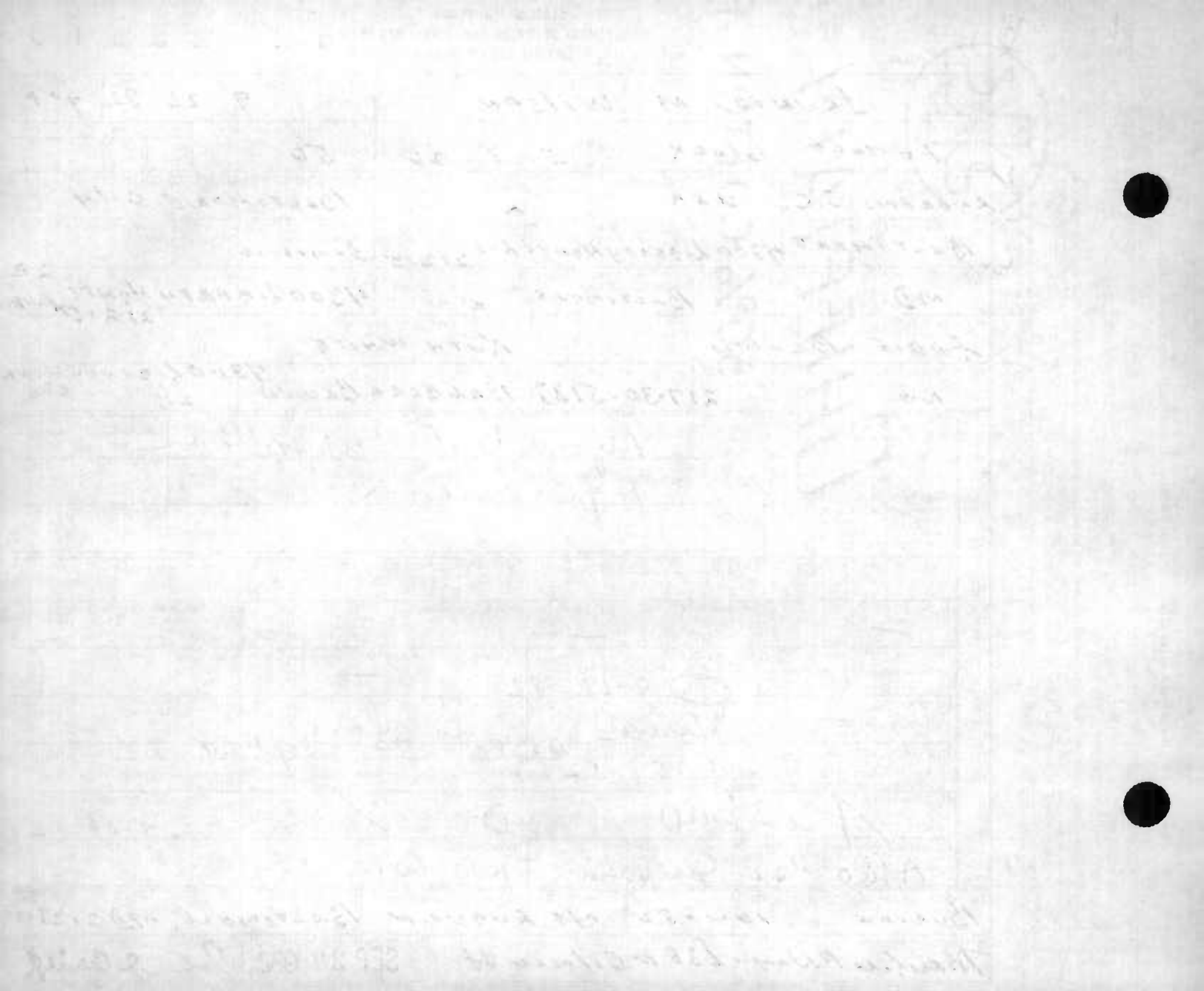
1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 6 1 8

REG. NO.

|                                                                                                                                                                                                                                                         |                              |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                              |  |                              |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                     |                              | FIRST MIDDLE LAST                                                                                                                                        |  | 2a. DATE OF DEATH                                                                                                                          |  | MONTH DAY YEAR                                                                               |  | 2b. HOUR                     |  |
| JENNIE M WILSON                                                                                                                                                                                                                                         |                              |                                                                                                                                                          |  | 9 26 82                                                                                                                                    |  | 7 <sup>PM</sup>                                                                              |  | M                            |  |
| 3. SEX                                                                                                                                                                                                                                                  | 4. RACE                      | 5. DATE OF BIRTH                                                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                                            |  | IF UNDER 1 YEAR                                                                              |  | IF UNDER 24 HRS              |  |
| FEMALE                                                                                                                                                                                                                                                  | BLACK                        | 5 3 26                                                                                                                                                   |  | 56                                                                                                                                         |  | MONTHS DAYS                                                                                  |  | HOURS MIN.                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                               | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                       |  |                                                                                              |  |                              |  |
| ANDERSON, S.C.                                                                                                                                                                                                                                          | USA                          |                                                                                                                                                          |  | BALTIMORE CITY MD.                                                                                                                         |  |                                                                                              |  |                              |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                               |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                                   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                              |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |  |                              |  |
| BALTIMORE                                                                                                                                                                                                                                               |                              | 4360 LEBERTY HAVEN AVE 21215                                                                                                                             |  | DOMESTIC                                                                                                                                   |  |                                                                                              |  |                              |  |
| 13a. STATE                                                                                                                                                                                                                                              |                              | 13b. COUNTY                                                                                                                                              |  | 13c. CITY OR TOWN                                                                                                                          |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS          |  |
| MD                                                                                                                                                                                                                                                      |                              |                                                                                                                                                          |  | BALTIMORE                                                                                                                                  |  |                                                                                              |  | 4300 LEBERTY HAVEN AVE 21215 |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                       |                              | 15. MOTHER'S MAIDEN NAME                                                                                                                                 |  |                                                                                                                                            |  |                                                                                              |  |                              |  |
| FOOTIE BROWN                                                                                                                                                                                                                                            |                              | RUTH WHITE                                                                                                                                               |  |                                                                                                                                            |  |                                                                                              |  |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                       |                              | 16b. SOCIAL SECURITY NO.                                                                                                                                 |  | 17. INFORMANT                                                                                                                              |  | ADDRESS                                                                                      |  |                              |  |
| NO                                                                                                                                                                                                                                                      |                              | 217-30-5187                                                                                                                                              |  | BARBARA BROWN                                                                                                                              |  | 4360 LEBERTY HAVEN AVE 21215                                                                 |  |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.                                                                                                                                                   |                              | IMMEDIATE CAUSE (a)                                                                                                                                      |  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                 |  |                              |  |
| 4100                                                                                                                                                                                                                                                    |                              | Myocardial Infarction                                                                                                                                    |  |                                                                                                                                            |  |                                                                                              |  |                              |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                          |                              | (b)                                                                                                                                                      |  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                             |  |                                                                                              |  |                              |  |
|                                                                                                                                                                                                                                                         |                              | Hypertension                                                                                                                                             |  |                                                                                                                                            |  |                                                                                              |  |                              |  |
|                                                                                                                                                                                                                                                         |                              | (c)                                                                                                                                                      |  |                                                                                                                                            |  |                                                                                              |  |                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                     |                              |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                              |  |                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |  | 20a. AUTOPSY?                                                                                                                              |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                               |  |                              |  |
| —                                                                                                                                                                                                                                                       |                              | —                                                                                                                                                        |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  |                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                      |                              | 21b. TIME OF INJURY                                                                                                                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |  |                                                                                              |  |                              |  |
|                                                                                                                                                                                                                                                         |                              | HOUR A.M. MONTH DAY YEAR                                                                                                                                 |  |                                                                                                                                            |  |                                                                                              |  |                              |  |
|                                                                                                                                                                                                                                                         |                              | P.M. 9-27 1982                                                                                                                                           |  |                                                                                                                                            |  |                                                                                              |  |                              |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                    |                              | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  | 21f. LOCATION                                                                                                                              |  |                                                                                              |  |                              |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                            |                              | Home                                                                                                                                                     |  | STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                              |  |                              |  |
|                                                                                                                                                                                                                                                         |                              |                                                                                                                                                          |  | april as above                                                                                                                             |  |                                                                                              |  |                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 25</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                              |                                                                                                                                                          |  |                                                                                                                                            |  |                                                                                              |  |                              |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                          |                              | DEGREE                                                                                                                                                   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED                                                                             |  |                              |  |
| Aldo P22-Guevara                                                                                                                                                                                                                                        |                              | MD                                                                                                                                                       |  |                                                                                                                                            |  | 9-27-82                                                                                      |  |                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                   |                              | 22e. ADDRESS                                                                                                                                             |  |                                                                                                                                            |  |                                                                                              |  |                              |  |
| Aldo P22-Guevara                                                                                                                                                                                                                                        |                              | 1000 Eager St.                                                                                                                                           |  |                                                                                                                                            |  |                                                                                              |  |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                               |                              | 23b. DATE                                                                                                                                                |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                         |  | 23d. LOCATION                                                                                |  |                              |  |
| Burial                                                                                                                                                                                                                                                  |                              | 10-1-82                                                                                                                                                  |  | MT AUGUST                                                                                                                                  |  | BALTIMORE, MD 21230                                                                          |  |                              |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                    |                              | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                 |  |                                                                                              |  |                              |  |
| Marshall P. Hays                                                                                                                                                                                                                                        |                              | 635 W. Gilman St                                                                                                                                         |  | SEP 27 1982                                                                                                                                |  | John J. Conner                                                                               |  |                              |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                   |                                               |                                                                                                                                                             |                                                         |                                                               |  |                                                                                     |  | REG. NO. 2 2 3 6 1 9 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|---------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|----------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>John Lee Wilson                                                                                                                                                                                                                                                                                                                                                               |                  |                                                                                                                                   |                                               |                                                                                                                                                             |                                                         | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>9 13 1982        |  | 2b. HOUR<br>M<br>12:15                                                              |  |                      |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                         | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 28 57                                                                                     | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>25 YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                                                                                                    | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>9 13 1982 | 7d. HOUR<br>a M                                               |  |                                                                                     |  |                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S.C.                                                                                                                                                                                                                                                                                                                                                                                      |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                               |                                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.   |  |                                                                                     |  |                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                 |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |                                               |                                                                                                                                                             |                                                         | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                   |  |                      |  |
| 13a. STATE<br>Md                                                                                                                                                                                                                                                                                                                                                                                                                       |                  | 13b. COUNTY<br>Balto.                                                                                                             |                                               | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |                                                         | 13e. STREET ADDRESS<br>1920 W. Baltimore Street               |  |                                                                                     |  |                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Linnion Wilson                                                                                                                                                                                                                                                                                                                                                                               |                  |                                                                                                                                   |                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Stuckey                                                                                          |                                                         |                                                               |  |                                                                                     |  |                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                            |                  | 16b. SOCIAL SECURITY NO.<br>220 64 4026                                                                                           |                                               | 17. INFORMANT ADDRESS<br>Elizabeth Wilson 1920 W. Baltimore St.                                                                                             |                                                         |                                                               |  |                                                                                     |  |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Stab wound of chest<br>9660<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |                  |                                                                                                                                   |                                               |                                                                                                                                                             |                                                         |                                                               |  |                                                                                     |  |                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                                                                                                                                                                                                                                         |                  |                                                                                                                                   |                                               |                                                                                                                                                             |                                                         |                                                               |  |                                                                                     |  |                      |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                 |                                               |                                                                                                                                                             |                                                         |                                                               |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                      |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                            |                  | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR<br>10:30 AM 9 12 19 82                                                                 |                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject stabbed                                                            |                                                         |                                                               |  |                                                                                     |  |                      |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                   |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street                                                             |                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>2500 Blk. W. Fairmount Ave., Balto. City, Md.                                                          |                                                         |                                                               |  |                                                                                     |  |                      |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |                                                                                                                                   |                                               |                                                                                                                                                             |                                                         |                                                               |  |                                                                                     |  |                      |  |
| ACTUAL SIGNATURE<br>Thomas D. Smith, M.D.                                                                                                                                                                                                                                                                                                                                                                                              |                  | TITLE (SPECIFY)<br>M.D. Deputy Chief MEDICAL EXAMINER                                                                             |                                               |                                                                                                                                                             |                                                         |                                                               |  | DATE SIGNED<br>9/13/82                                                              |  |                      |  |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                        |                  | ADDRESS<br>111 Penn St. Balto., MD.                                                                                               |                                               |                                                                                                                                                             |                                                         |                                                               |  |                                                                                     |  |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                    |                  | 23b. DATE<br>9-18-82                                                                                                              |                                               | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.                                                                                                       |                                                         | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.  |  |                                                                                     |  |                      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Brown/Thompson F.H.                                                                                                                                                                                                                                                                                                                                                                                    |                  |                                                                                                                                   |                                               | ADDRESS<br>1913 W. Balto. St.                                                                                                                               |                                                         | 25a. DATE REC'D. BY REGISTRAR<br>SEP 14 1982                  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel                                        |  |                      |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the original should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                        |  |                                                                                                                                                             |                                                          |                                                                                                 |  |                                                                                                                            |                                   |                                              |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------|----------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                        |  |                                                                                                                                                             | 8 2 2 3 6 2 0<br>REG. NO.                                |                                                                                                 |  |                                                                                                                            |                                   |                                              |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>William WINCHESTER Jr.                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                        |  |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>September 3, 1982 |                                                                                                 |  |                                                                                                                            |                                   | 2b. HOUR<br>5:07P M                          |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br>Black                                                                                                                       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 8 33                                                                                                                |                                                          | 6. AGE (IN YEARS LAST BIRTHDAY)<br>49 YRS.                                                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                             |                                   | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                    |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |                                                                                                                            |                                   |                                              |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |  |                                                                                                                                                             |                                                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY |                                              |  |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 13b. COUNTY<br>-----                                                                                                                   |  | 13c. CITY OR TOWN<br>Greater Pen                                                                                                                            |                                                          | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>606 Pennsylvania Avenue                                                                             |                                   |                                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Winchester                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Hester Gardner                                                                                             |                                                          |                                                                                                 |  |                                                                                                                            |                                   |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A                                                                         |  | 17. INFORMANT<br>ADDRESS<br>Hester Winchester 1931 N. Patterson                                                                                             |                                                          |                                                                                                 |  |                                                                                                                            |                                   |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br><b>2030</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Multiple Pathological Fractures</b><br>(b) <b>Secondary to Multiple Metastatic Myeloma</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____                             |  |                                                                                                                                        |  |                                                                                                                                                             |                                                          |                                                                                                 |  |                                                                                                                            |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                        |  |                                                                                                                                                             |                                                          |                                                                                                 |  |                                                                                                                            |                                   |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |  |                                                                                                                                                             |                                                          | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                          |                                                                                                 |  |                                                                                                                            |                                   |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                          |                                                                                                 |  |                                                                                                                            |                                   |                                              |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 23, 1982</b> , to <b>September 3, 1982</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>September 3, 1982</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death. |  |                                                                                                                                        |  |                                                                                                                                                             |                                                          |                                                                                                 |  |                                                                                                                            |                                   |                                              |  |
| 22b. SIGNATURE<br><i>Gwendolyn Bolling</i>                                                                                                                                                                                                                                                                                                                                                                                                              |  | DEGREE                                                                                                                                 |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |                                                          |                                                                                                 |  | 22c. DATE SIGNED<br>9/3/82                                                                                                 |                                   |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Gwendolyn Bolling, M.D.                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                        |  | 22e. ADDRESS<br>c/o Maryland General Hospital                                                                                                               |                                                          |                                                                                                 |  |                                                                                                                            |                                   |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br>/8/82                                                                                                                     |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Eastview Mem. Pk.                                                                                                     |                                                          | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md-                                     |  |                                                                                                                            |                                   |                                              |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm. C. March F/H 1101 E. North Avenue                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 8 1982                                                                                                                 |                                                          | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Conner</i>                                             |  |                                                                                                                            |                                   |                                              |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                        |  | 8 2 2 3 6 2 1<br>REG. NO.                                                                                                                                  |  |                                                                                                                         |  |                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HELEN ELIZABETH WIPFIELD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                        |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>September 10, 1982</b>                                                                                              |  |                                                                                                                         |  | 2b. HOUR MIN<br><b>7:30 A M</b>                            |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4 RACE<br><b>White</b>                                                                                                                 |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Sept. 5, 1912</b>                                                                                                    |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.                                                                        |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                           |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                        |  |                                                            |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1405 West 41st Street</b> |  |                                                                                                                                                            |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                                       |  | 12b. KIND OF BUSINESS OR INDUSTRY                          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>Maryland = = = Baltimore</b>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                        |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                               |  | 13e. STREET ADDRESS<br><b>14-5 West 41st St. 21211</b>                                                                  |  |                                                            |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Herbert P. Chaney</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary = Wood</b>                                                                                           |  |                                                                                                                         |  |                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.<br><b>212-03-7417-B</b>                                                                                       |  | 17. INFORMANT ADDRESS<br><b>George Wipfield as above</b>                                                                                                   |  |                                                                                                                         |  |                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a): <b>4100 Acute heart attack</b><br>DUE TO, OR AS A CONSEQUENCE OF (b): <b>Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c): <b>Chronic of Colon</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Alzheimer's Disease</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <b>5 yrs.</b> |  |                                                                                                                                        |  |                                                                                                                                                            |  |                                                                                                                         |  |                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                            |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                             |  |                                                                                                                         |  |                                                            |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>Sept 10 1982</b>                                                                                      |  |                                                                                                                         |  |                                                            |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>July 82</b> to <b>Sept 10 82</b> , and that in my (best) opinion death occurred on the date and hour and from the causes stated above; (2) (myself) did not view the body after death.                                                                                                                                                                                                                                                                  |  |                                                                                                                                        |  |                                                                                                                                                            |  |                                                                                                                         |  |                                                            |
| 22b. SIGNATURE <b>William G. Helfrich M.D.</b> DEGREE <b>M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                        |  | 22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>            |  | 22d. DATE SIGNED<br><b>9/10/82</b>                                                                                      |  |                                                            |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>William G. Helfrich M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                        |  | 22f. ADDRESS<br><b>5006 Roland Avenue</b>                                                                                                                  |  |                                                                                                                         |  |                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br><b>9/13/82</b>                                                                                                            |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>                                                                                                 |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore. Maryland</b>                                                   |  |                                                            |
| 24. FUNERAL DIRECTOR NAME<br><b>Raymond C. Fink</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                        |  | ADDRESS<br><b>Glen Burnie, Md.</b>                                                                                                                         |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 14 1982</b>                                                                     |  |                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                        |  | 25b. REGISTRAR'S SIGNATURE<br><b>John S. Baird</b>                                                                                                         |  |                                                                                                                         |  |                                                            |



*[Faint, mostly illegible text, possibly a ledger or form with multiple columns and rows.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                             |  |  |                                                                                                                        |  |                                                      |                                                                                                                                                             |  |                                                                           |                                                             | 8                                                                                                                                                                                              | 2                           | 2                                       | 3                                        | 6 | 2 | 2 |                                 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------|-------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-----------------------------------------|------------------------------------------|---|---|---|---------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                           |  |  |                                                                                                                        |  |                                                      |                                                                                                                                                             |  |                                                                           |                                                             | REG. NO.                                                                                                                                                                                       |                             |                                         |                                          |   |   |   |                                 |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>HILDA P. WISNER                                                                                                                                                                                                                                                                         |  |  |                                                                                                                        |  |                                                      |                                                                                                                                                             |  |                                                                           |                                                             | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR<br>Sept 2 82 12 48 P.M.                                                                                                                              |                             |                                         |                                          |   |   |   |                                 |  |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                 |  |  | 4. RACE<br>CAUC.                                                                                                       |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>11/25/15          |                                                                                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.                                |                                                             |                                                                                                                                                                                                | IF UNDER 1 YEAR MONTHS DAYS |                                         | IF UNDER 24 HRS. HOURS MIN.              |   |   |   |                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.                                                                                                                                                                                                                                                                                                 |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.                                                                                   |  |                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD. |                                                                                                                                                                                                |                             |                                         |                                          |   |   |   |                                 |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                           |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>KESWICK HOME |  |                                                      |                                                                                                                                                             |  |                                                                           |                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED                                                                                                                       |                             |                                         | 12b. KIND OF BUSINESS OR INDUSTRY<br>--- |   |   |   |                                 |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD. 13b. COUNTY --- 13c. CITY OR TOWN BALTO.                                                                                                                                                                                          |  |  |                                                                                                                        |  |                                                      |                                                                                                                                                             |  |                                                                           |                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                |                             |                                         | 13e. STREET ADDRESS<br>704 BUNNECKE AVE. |   |   |   |                                 |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>? ---                                                                                                                                                                                                                                                                                                     |  |  |                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>? ---  |                                                                                                                                                             |  |                                                                           |                                                             |                                                                                                                                                                                                |                             |                                         |                                          |   |   |   |                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO                                                                                                                                                                                                                                                                             |  |  |                                                                                                                        |  | 16b. SOCIAL SECURITY NO. ---                         |                                                                                                                                                             |  | 17. INFORMANT ADDRESS<br>DAUGHTER                                         |                                                             |                                                                                                                                                                                                |                             |                                         |                                          |   |   |   |                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4292 Cerebrovascular Accident<br>(b) DUE TO, OR AS A CONSEQUENCE OF 8500<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |                                                                                                                        |  |                                                      |                                                                                                                                                             |  |                                                                           |                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Instant<br>9 yrs                                                                                                                               |                             |                                         |                                          |   |   |   |                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)<br>Diabetes Mellitus                                                                                                                                                                                        |  |  |                                                                                                                        |  |                                                      |                                                                                                                                                             |  |                                                                           |                                                             |                                                                                                                                                                                                |                             |                                         |                                          |   |   |   |                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                           |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                       |  |                                                      |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                     |                             |                                         |                                          |   |   |   |                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                               |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                |  |                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                           |                                                             |                                                                                                                                                                                                |                             |                                         |                                          |   |   |   |                                 |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                           |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                    |  |                                                      | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                           |                                                             |                                                                                                                                                                                                |                             |                                         |                                          |   |   |   |                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 9 19 80 to Sept 2 19 82, that (I) (we) lost saw the deceased alive on Sept 2 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                              |  |  |                                                                                                                        |  |                                                      |                                                                                                                                                             |  |                                                                           |                                                             | 22b. SIGNATURE DEGREE<br>John E. Richardson M.D.<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                             |                                         |                                          |   |   |   | 22c. DATE SIGNED<br>Sept 2 1982 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                            |  |  |                                                                                                                        |  | 22e. ADDRESS                                         |                                                                                                                                                             |  |                                                                           |                                                             |                                                                                                                                                                                                |                             |                                         |                                          |   |   |   |                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                              |  |  | 23b. DATE<br>9/7/82                                                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY<br>LORRAINE PARK. |                                                                                                                                                             |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTO MD.                      |                                                             |                                                                                                                                                                                                |                             |                                         |                                          |   |   |   |                                 |  |
| 24. FUNERAL DIRECTOR (NAME)<br>Paul E. Chenoweth 3rd.                                                                                                                                                                                                                                                                                            |  |  |                                                                                                                        |  | ADDRESS<br>3617 Chestnut Ave.                        |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 7 1982                               |                                                             |                                                                                                                                                                                                |                             | REGISTRAR'S SIGNATURE<br>John J. Canine |                                          |   |   |   |                                 |  |

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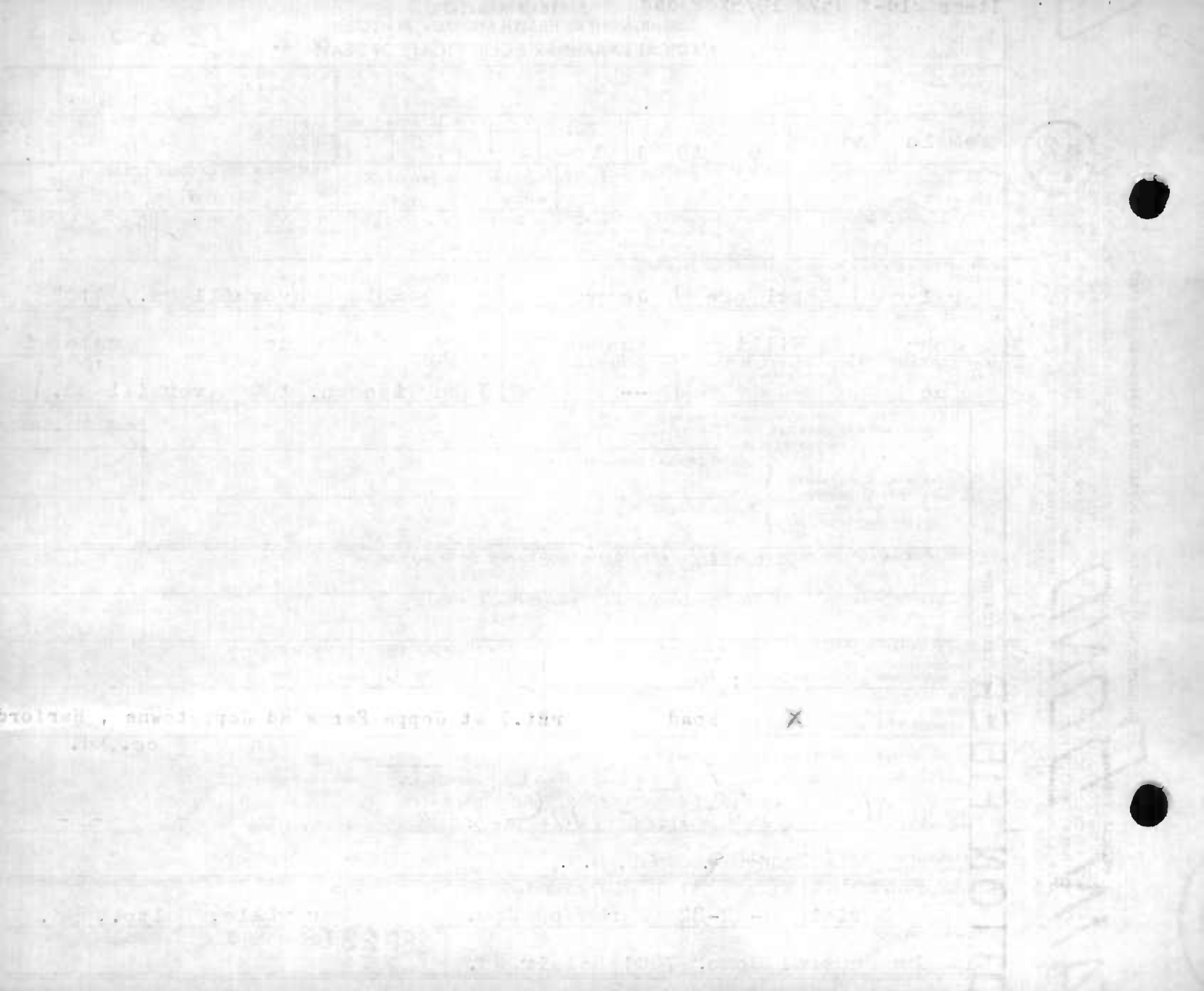
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                  |  |                                                                                                                                            |  |                                           |  |                                                                                                                                                          |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |                                                                      |  |  |  |                                                                                     |  |                                            |  | REG. NO. 2 2 3 6 2 3     |  |                   |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|--|--|-------------------------------------------------------------------------------------|--|--------------------------------------------|--|--------------------------|--|-------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) Courtney L. Wissman                                                                                                                                                                                                                                                                                                                                                                                |  |                  |  |                                                                                                                                            |  |                                           |  |                                                                                                                                                          |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR 9 19 82                                                       |  |                                                                      |  |  |  |                                                                                     |  |                                            |  | 2b. HOUR<br>M 1:15 P. M. |  |                   |  |
| 3. SEX<br>female                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br>white |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR 6 19 81                                                                                                 |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>1 YRS. |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.                                                                                                                    |  | IF UNDER 24 HRS.                                                                                        |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR 9 19 82                   |  |  |  |                                                                                     |  |                                            |  |                          |  | 2d. HOUR<br>P. M. |  |
| BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                      |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                        |  |                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                                                         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD           |  |  |  |                                                                                     |  |                                            |  |                          |  |                   |  |
| 11. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                 |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Johns Hopkins Hospital - DOA |  |                                           |  |                                                                                                                                                          |  |                                                                                                         |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)        |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                   |  |                                            |  |                          |  |                   |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                  |  | 13b. CITY OR TOWN<br>Joppa                                                                                                                 |  |                                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                          |  |                                                                                                         |  | 13e. STREET ADDRESS<br>100 Haverhill Rd., 21085                      |  |  |  |                                                                                     |  |                                            |  |                          |  |                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST John William Wissman III                                                                                                                                                                                                                                                                                                                                                                        |  |                  |  |                                                                                                                                            |  |                                           |  |                                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST Mary Jane Pusloski                                        |  |                                                                      |  |  |  |                                                                                     |  |                                            |  |                          |  |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) no                                                                                                                                                                                                                                                                                                                                                               |  |                  |  | 16b. SOCIAL SECURITY NO.<br>--                                                                                                             |  |                                           |  | 17. INFORMANT<br>John Wissman, 100 Haverhill Rd.                                                                                                         |  |                                                                                                         |  |                                                                      |  |  |  | ADDRESS<br>21085                                                                    |  |                                            |  |                          |  |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>8121 IMMEDIATE CAUSE (a) Blunt Trauma to Abdomen<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> .<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                   |  |                  |  |                                                                                                                                            |  |                                           |  |                                                                                                                                                          |  |                                                                                                         |  |                                                                      |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                        |  |                                            |  |                          |  |                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).                                                                                                                                                                                                                                                                                                    |  |                  |  |                                                                                                                                            |  |                                           |  |                                                                                                                                                          |  |                                                                                                         |  |                                                                      |  |  |  |                                                                                     |  |                                            |  |                          |  |                   |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                          |  |                                           |  |                                                                                                                                                          |  |                                                                                                         |  |                                                                      |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                            |  |                          |  |                   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                         |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR 11:35 PM 9 19 82                                                                           |  |                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>passenger in auto/fixed object impact                                   |  |                                                                                                         |  |                                                                      |  |  |  |                                                                                     |  |                                            |  |                          |  |                   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                      |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>roas                                                                        |  |                                           |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Rt. 7 at Joppa Farms Rd., Joppatown, Harford co., Md.                                               |  |                                                                                                         |  |                                                                      |  |  |  |                                                                                     |  |                                            |  |                          |  |                   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                  |  |                                                                                                                                            |  |                                           |  |                                                                                                                                                          |  |                                                                                                         |  |                                                                      |  |  |  |                                                                                     |  |                                            |  |                          |  |                   |  |
| ACTUAL SIGNATURE<br>Dennis F. Smyth, M.D.                                                                                                                                                                                                                                                                                                                                                                                              |  |                  |  | TITLE (SPECIFY)<br>Assistant M.D.                                                                                                          |  |                                           |  | MEDICAL EXAMINER                                                                                                                                         |  |                                                                                                         |  | DATE SIGNED<br>9-20-82                                               |  |  |  |                                                                                     |  |                                            |  |                          |  |                   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) Dennis F. Smyth, M.D.                                                                                                                                                                                                                                                                                                                                                                               |  |                  |  | ADDRESS<br>111 Penn Street                                                                                                                 |  |                                           |  |                                                                                                                                                          |  |                                                                                                         |  |                                                                      |  |  |  |                                                                                     |  |                                            |  |                          |  |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) Burial                                                                                                                                                                                                                                                                                                                                                                                    |  |                  |  | 23b. DATE<br>9-22-82                                                                                                                       |  |                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cem.                                                                                                      |  |                                                                                                         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Parkville, Balto., Md. |  |  |  |                                                                                     |  |                                            |  |                          |  |                   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Lassahn Funeral Home, 7401 Belair Rd.                                                                                                                                                                                                                                                                                                                                                          |  |                  |  |                                                                                                                                            |  |                                           |  |                                                                                                                                                          |  |                                                                                                         |  |                                                                      |  |  |  | 25. DATE RECORDED BY REGISTRAR<br>SEP 23 1982                                       |  | 26. REGISTRAR'S SIGNATURE<br>John J. Smith |  |                          |  |                   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                  |  |                                                                                                                                       |  |                                                                    | 8 2 2 3 6 2 4<br>REG. NO.                                                                                                                                   |                                                                                                                                                      |                                                               |                                                                              |  |                                                                                                                               |                                               |                               |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|-------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM WOLF</b>                                                                                                                                                                                                                                                                               |  |                                                                                                                                       |  |                                                                    | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>9 10 82</b>                                                                                                          |                                                                                                                                                      |                                                               |                                                                              |  | 2b. HOUR<br><b>12<sup>15</sup> P.M.</b>                                                                                       |                                               |                               |  |  |
| 1. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br><b>W</b>                                                                                                                   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>9 8 1896</b>                 |                                                                                                                                                             |                                                                                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS              |                                                                              |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                |                                               | IF UNDER 24 HRS<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>                                                                                           |  |                                                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                      |                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b> MD.                |  |                                                                                                                               |                                               |                               |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTO. CITY HOSP.</b> |  |                                                                    |                                                                                                                                                             |                                                                                                                                                      |                                                               | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>-</b> |  |                                                                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b> |                               |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b>                                                                                                                                                                                                                  |  | 13b. COUNTY <b>BALTO</b>                                                                                                              |  | 13c. CITY OR TOWN<br><b>ESSEX</b>                                  |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                      |                                                               | 13e. STREET ADDRESS<br><b>RIVERVIEW N. H.</b>                                |  |                                                                                                                               |                                               |                               |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SIMON WOLF</b>                                                                                                                                                                                                                                                                           |  |                                                                                                                                       |  |                                                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>PAULINE BRUBECK</b>                                                                                     |                                                                                                                                                      |                                                               |                                                                              |  |                                                                                                                               |                                               |                               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>                                                                                                                                                                                                                                                        |  |                                                                                                                                       |  |                                                                    | 16b. SOCIAL SECURITY NO.<br><b>216-12-9116</b>                                                                                                              |                                                                                                                                                      | 17. INFORMANT ADDRESS<br><b>GEORGE WOLF 5807 WAYCROSS RD.</b> |                                                                              |  |                                                                                                                               |                                               |                               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b><br><b>5119</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>(R) Bloody Pleural Effusion</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>UNKNOWN</b>                    |  |                                                                                                                                       |  |                                                                    |                                                                                                                                                             |                                                                                                                                                      |                                                               |                                                                              |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                               |                                               |                               |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                   |  |                                                                                                                                       |  |                                                                    |                                                                                                                                                             |                                                                                                                                                      |                                                               |                                                                              |  |                                                                                                                               |                                               |                               |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                   |                                                                                                                                                             |                                                                                                                                                      |                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>    |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                               |                               |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                              |  |                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |                                                               |                                                                              |  |                                                                                                                               |                                               |                               |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                          |  |                                                                                                                                       |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |                                                               |                                                                              |  |                                                                                                                               |                                               |                               |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-26, 1982</b> to <b>9-10, 1982</b> , that (I) (we) last saw the deceased alive on <b>9-10, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                       |  |                                                                    |                                                                                                                                                             |                                                                                                                                                      |                                                               |                                                                              |  |                                                                                                                               |                                               |                               |  |  |
| 22b. SIGNATURE<br><b>Robert A. Weisgau</b> MD                                                                                                                                                                                                                                                                                         |  |                                                                                                                                       |  |                                                                    |                                                                                                                                                             | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                               |                                                                              |  | 22c. DATE SIGNED<br><b>9/10/82</b>                                                                                            |                                               |                               |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT A. WEISGAU MD</b>                                                                                                                                                                                                                                                                  |  |                                                                                                                                       |  |                                                                    |                                                                                                                                                             | 22e. ADDRESS<br><b>BALTIMORE CITY HOSPITAL</b>                                                                                                       |                                                               |                                                                              |  |                                                                                                                               |                                               |                               |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>                                                                                                                                                                                                                                                                            |  |                                                                                                                                       |  | 23b. DATE<br><b>9/13/82</b>                                        |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAK LAWN</b>                                                                                                |                                                               |                                                                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO MD.</b>                                                                |                                               |                               |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>CONNELLY FUNERAL HOME OF DUNDALK</b>                                                                                                                                                                                                                                                       |  |                                                                                                                                       |  |                                                                    |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 15 1982</b>                                                                                                  |                                                               | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                             |  |                                                                                                                               |                                               |                               |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                   |  |                                                                                                           |  |                                                                                                                                                  |  |                                                                                                                                            |  |                                                                |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                 |  | 8 2 2 3 6 2 5<br>REG. NO.                                                                                 |  |                                                                                                                                                  |  |                                                                                                                                            |  |                                                                |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                    |  | FIRST                                                                                                     |  | MIDDLE                                                                                                                                           |  | LAST                                                                                                                                       |  | 2a. DATE OF DEATH                                              |  |
| BETTY                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  |                                                                                                                                                  |  | WOLFF                                                                                                                                      |  | MONTH DAY YEAR<br>9 10 82                                      |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE                                                                                                   |  | 5. DATE OF BIRTH                                                                                                                                 |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                                            |  | 7b. HOUR                                                       |  |
| Female                                                                                                                                                                                                                                                                                                                                                                                                 |  | White                                                                                                     |  | 12 18 08                                                                                                                                         |  | 73                                                                                                                                         |  | 1:30 <sup>a</sup> <sub>M</sub>                                 |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                       |  |                                                                |  |
| Virginia                                                                                                                                                                                                                                                                                                                                                                                               |  | U.S.                                                                                                      |  |                                                                                                                                                  |  | Balto. City                                                                                                                                |  | MD.                                                            |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Balto.                                                                                                                                                                                                                                                                                                                                                                                                 |  | Forest Haven Nurs. Home                                                                                   |  |                                                                                                                                                  |  | Practical Nurse                                                                                                                            |  |                                                                |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY                                                                                               |  | 13c. CITY OR TOWN                                                                                                                                |  | 13d. INSIDE CITY LIMITS?                                                                                                                   |  | 13e. STREET ADDRESS                                            |  |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                           |  | Balto.                                                                                                                                           |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 3708 Greenmount Ave.                                           |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                      |  | MIDDLE                                                                                                    |  | LAST                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME                                                                                                                   |  | MIDDLE LAST                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                           |  |                                                                                                                                                  |  |                                                                                                                                            |  |                                                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)                                                   |  | 17. INFORMANT                                                                                                                                    |  | ADDRESS                                                                                                                                    |  |                                                                |  |
| No                                                                                                                                                                                                                                                                                                                                                                                                     |  | 219-01-6595                                                                                               |  |                                                                                                                                                  |  |                                                                                                                                            |  |                                                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cancer Lung with Metastases</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>J</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>8 months</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                           |  |                                                                                                                                                  |  |                                                                                                                                            |  |                                                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                                                                                                                       |  |                                                                                                           |  |                                                                                                                                                  |  |                                                                                                                                            |  |                                                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  |                                                                                                                                                  |  | 20a. AUTOPSY?                                                                                                                              |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                           |  |                                                                                                                                                  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)                                                                   |  |                                                                                                                                            |  |                                                                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                           |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                |  |                                                                                                                                            |  |                                                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/29</u> , 19 <u>81</u> , to <u>9/10</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>9-7</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did, did not) view the body after death.                                       |  |                                                                                                           |  |                                                                                                                                                  |  |                                                                                                                                            |  |                                                                |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                         |  | DEGREE                                                                                                    |  |                                                                                                                                                  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED                                               |  |
| <u>Harold Bobb</u>                                                                                                                                                                                                                                                                                                                                                                                     |  | MD                                                                                                        |  |                                                                                                                                                  |  |                                                                                                                                            |  | 9-13-82                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                  |  | 22e. ADDRESS                                                                                              |  |                                                                                                                                                  |  |                                                                                                                                            |  |                                                                |  |
| HAROLD B. BOB                                                                                                                                                                                                                                                                                                                                                                                          |  | 7220 Park Heights Ave 21208                                                                               |  |                                                                                                                                                  |  |                                                                                                                                            |  |                                                                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                                           |  | 23b. DATE                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                                                                 |  |                                                                |  |
| Removal                                                                                                                                                                                                                                                                                                                                                                                                |  | 9/10/82                                                                                                   |  |                                                                                                                                                  |  |                                                                                                                                            |  |                                                                |  |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                                                           |  | ADDRESS                                                                                                   |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                    |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                 |  |                                                                |  |
| Anatomy Board                                                                                                                                                                                                                                                                                                                                                                                          |  | Balto., Md.                                                                                               |  | SEP 20 1982                                                                                                                                      |  | <u>John J. Conner</u>                                                                                                                      |  |                                                                |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed without 23 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

|                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                            |                                                                                                    |                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| item 5,0,14 #G571 9/24/82 ph                                                                                                                                                                                                                                                                                                                                       |                                                                                                                            | STATE OF MARYLAND                                                                                  |                                                                                                                            |
| 1- STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                            | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                    |                                                                                                                            |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>SHAMICA WOMACK</b>                                                                                                                                                                                                                                                                                                           |                                                                                                                            | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>SEPT. 15, 1982</b>                                          |                                                                                                                            |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                            | 4 RACE<br><b>Black</b>                                                                                                     | 2b. HOUR P<br><b>9:05 M</b>                                                                        |                                                                                                                            |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8-9-10-15-82-81</b>                                                                                                                                                                                                                                                                                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>1</b> YRS.                                                                           | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>1 5</b>                                            |                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                  |                                                                                                                            |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF SUCH AS STRAIGHT HOME)<br><b>THE JOHNS HOPKINS HOSPITAL</b> | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |                                                                                                                            |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                      | 13b. COUNTY<br><b>Baltimore</b>                                                                                            | 13c. STREET ADDRESS<br><b>3902 Duvall Avenue</b>                                                   |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Larry</b> <b>Womack</b> <b>Warwick</b>                                                                                                                                                                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Belinda</b> <b>Mullins</b>                                             |                                                                                                    |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                      | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>                                                                                     | 17. INFORMANT ADDRESS<br><b>Belinda Mullins 3902 Duvall Avenue</b>                                 |                                                                                                                            |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiorespiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>probable fulminant sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>immunocompromised patient</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                                                                                                            |                                                                                                    |                                                                                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b>S/P bacterial meningitis &amp; resulting MR, CP, hypopituitarism, seizures</b>                                                                                                                                           |                                                                                                                            |                                                                                                    |                                                                                                                            |
| 19a. DATE OF OPERATION<br><b>NA</b>                                                                                                                                                                                                                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>NA</b>                                                              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>NA</b>                                                                                                                                                                                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>NA</b> <b>19</b>                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>NA</b>        |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> <b>NA</b>                                                                                                                                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>NA</b>                                        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>NA</b>                                     |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9:15</b> , 19 <b>82</b> , to <b>9:15</b> , 19 <b>82</b> , that (we) last saw the deceased alive on <b>9:15</b> , 19 <b>82</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.                  |                                                                                                                            |                                                                                                    |                                                                                                                            |
| 22b. SIGNATURE<br><b>Lawrence Epple, M.D.</b>                                                                                                                                                                                                                                                                                                                      |                                                                                                                            | 22c. DATE SIGNED<br><b>9.15.82</b>                                                                 |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lawrence Epple, M.D.</b>                                                                                                                                                                                                                                                                                               |                                                                                                                            | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>                                                      |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                      | 23b. DATE<br><b>9/17/82</b>                                                                                                | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Eastview Mem pk</b>                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md</b>                                                          |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/ h1101 E. North Ave</b>                                                                                                                                                                                                                                                                                  |                                                                                                                            | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>SEP 21 1982</b> <b>John J. Camm</b> |                                                                                                                            |

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 08-01-2010 BY 60322 UCBAW/SJS

RECEIVED

WASHINGTON CITY

THE UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON



2010-08-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                            |  |                                                                                                                                                             | 7 2 2 3 6 2 7<br>REG. NO.                                                         |                                                                                                        |                                                  |                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                            |  |                                                                                                                                                             |                                                                                   |                                                                                                        |                                                  |                                                                                                                            |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Caroline E WOOD</b>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                            |  |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>September 3, 1982</b>                      |                                                                                                        |                                                  | 2b. HOUR<br><b>3:40a M</b>                                                                                                 |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br><b>White</b>                                                                                                                    |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Jan. 12, 1898</b>                                                                                                     |                                                                                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.                                                      |                                                  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. County, Md.</b>                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>-U.S.A.</b>                                                                                             |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                                     |                                                  |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |                                                                                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |                                                                                                        | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>----</b> |                                                                                                                            |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY<br><b>----</b>                                                                                                                 |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                                                                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>        |                                                  | 13e. STREET ADDRESS<br><b>619 N. Curley Street</b>                                                                         |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>George Eberling</b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                            |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Marie Gilbert</b>                                                                                          |                                                                                   |                                                                                                        |                                                  |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br><b>- 212-09-5126-</b>                                                                                                           |                                                                                   | 17. INFORMANT ADDRESS<br><b>Baltimore, Md. 21222.</b><br><b>Mr. George E. Wood - 70 Navista Avenue</b> |                                                  |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>4100</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Coronary Artery disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>right Cerebral Vascular accident</b> |  |                                                                                                                                            |  |                                                                                                                                                             |                                                                                   |                                                                                                        |                                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                                                 |  |                                                                                                                                            |  |                                                                                                                                                             |                                                                                   |                                                                                                        |                                                  |                                                                                                                            |
| <b>right Cerebral Vascular accident</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                            |  |                                                                                                                                                             |                                                                                   |                                                                                                        |                                                  |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                           |  |                                                                                                                                                             |                                                                                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |                                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                   |                                                                                                        |                                                  |                                                                                                                            |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                        |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |                                                                                   |                                                                                                        |                                                  |                                                                                                                            |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>1 August 20, 19 82</b> , to <b>September 3, 19 82</b> , that X (we) last saw the deceased alive on <b>September 3, 19 82</b> , and that in X (y) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.                                       |  |                                                                                                                                            |  |                                                                                                                                                             |                                                                                   |                                                                                                        |                                                  |                                                                                                                            |
| 22b. SIGNATURE<br><b>Keith I. Adams M.D.</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                            |  |                                                                                                                                                             |                                                                                   | DEGREE<br><b>M.D.</b>                                                                                  |                                                  | 22c. DATE SIGNED<br><b>9/3/82</b>                                                                                          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Keith I. Adams, M.D.</b>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                            |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>                                                                                                        |                                                                                   |                                                                                                        |                                                  |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                           |  | 23b. DATE<br><b>Sept. 7, 1982</b>                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem. Park</b>                                                                                          |                                                                                   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Howard County, Md.</b>                                   |                                                  |                                                                                                                            |
| 24. FUNERAL DIRECTOR NAME<br><b>John A. Moran, Jr.</b>                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                            |  | ADDRESS<br><b>3000 E. Baltimore St. - Baltimore, Md. 21224</b>                                                                                              |                                                                                   | 25a. REC'D BY REGISTRAR<br><b>SEP 7 1982</b>                                                           |                                                  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>                                                                        |

841

Intentional homicide

0100110101

(continued)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 2 3 6 2 8  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                         |  |                                                                                                                                                  |                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>John R Woodland</i>                                                                                                                                                                                                                                                                                                                                                  |                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>9/9/82</i> <del>4/17/82</del> |  | 2b. HOUR<br><i>7:00 A.M.</i>                                                                                                                     |                                                 |
| 3. SEX<br><i>M</i>                                                                                                                                                                                                                                                                                                                                                                                                                  | 4. RACE<br><i>Black</i> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>4 17 19</i>                    |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>63</i> YRS.                                                                                                |                                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                                                                        |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                 |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City,</i> MD.                                                                                                                                                                                                                                                                                                                                                                  |                         | 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>SINAI Hospital</i>               |                                                 |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                                                                                                                                                                                                                                                                                                    |                         | 12b. KIND OF BUSINESS OR INDUSTRY                                       |  |                                                                                                                                                  |                                                 |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                     |                         | 13b. COUNTY<br><i>Baltimore</i>                                         |  | 13c. CITY OR TOWN<br><i>Baltimore</i>                                                                                                            |                                                 |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                     |                         | 13e. STREET ADDRESS<br><i>3413 Royce Avenue</i>                         |  |                                                                                                                                                  |                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Joseph Woodland</i>                                                                                                                                                                                                                                                                                                                                                                    |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Lillian Young</i>   |  |                                                                                                                                                  |                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>Yes</i>                                                                                                                                                                                                                                                                                                                                                  |                         | 16b. SOCIAL SECURITY NO.<br><i>218-07-6220</i>                          |  | 17. INFORMANT<br>ADDRESS<br><i>Lula Woodland 3413 Royce Avenue</i>                                                                               |                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><i>4275 IMMEDIATE CAUSE (a) CARDIOPULMONARY arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>hx of heart disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a) _____ |                         |                                                                         |  |                                                                                                                                                  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                              |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                        |                                                 |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                       |                         |                                                                         |  |                                                                                                                                                  |                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                             |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)                                                                   |                                                 |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                           |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                |                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 9</i> , 19 <i>82</i> , to <i>Sept 9</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                               |                         |                                                                         |  |                                                                                                                                                  |                                                 |
| 22b. SIGNATURE<br><i>J M Starr</i>                                                                                                                                                                                                                                                                                                                                                                                                  |                         | DEGREE                                                                  |  | 22c. DATE SIGNED<br><i>9/9/82</i>                                                                                                                |                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Jax M Starr</i>                                                                                                                                                                                                                                                                                                                                                                         |                         | 22e. ADDRESS<br><i>SINAI Emergency Room</i>                             |  |                                                                                                                                                  |                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>BURIAL</i>                                                                                                                                                                                                                                                                                                                                                                       |                         | 23b. DATE<br><i>8/14/82</i>                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Md. Veteran Cem</i>                                                                                     |                                                 |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Crownsville Md.</i>                                                                                                                                                                                                                                                                                                                                                                |                         |                                                                         |  |                                                                                                                                                  |                                                 |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Wm. C. Marcq F/ h 1101 E. North Ave.</i>                                                                                                                                                                                                                                                                                                                                                 |                         | 25a. DATE RECEIVED BY REGISTRAR<br><i>SEP 10 1982</i>                   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Connelley</i>                                                                                           |                                                 |

SEP 10 1988 - Jones Creek



SEP 10 1988

SEP 10 1988

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                         |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                        |  |                                                                                              |  | 8 2 2 3 6 2 9<br>REG. NO.                                                                                                                  |  |                                                                                                                         |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Mary Ellen Woods</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                         |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>9 14 82</b>                                                                                                          |  |                                                                                              |  | 2b. HOUR<br><b>M</b>                                                                                                                       |  |                                                                                                                         |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br><b>Black</b>                                                                                                                 |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>5 23 28</b>                                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54 YRS.</b>                                            |  | IF UNDER 1 YEAR MONTHS DAYS<br><b>54</b>                                                                                                   |  | IF UNDER 24 HRS. HOURS MIN.<br><b>54</b>                                                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore- City, MD.</b>                          |  |                                                                                                                                            |  |                                                                                                                         |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1223 N. Luzerne Avenue</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                          |  |                                                                                                                         |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 13b. COUNTY                                                                                                                             |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1223 N. Luzerne Avenue</b>                                                                                       |  |                                                                                                                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Robert Clay</b>                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Bessie Smith</b>                                                                                           |  |                                                                                              |  |                                                                                                                                            |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.<br><b>285-26-7288</b>                                                                                          |  | 17. INFORMANT ADDRESS<br><b>Lenis Woods 1223 N. Luzerne Avenue</b>                                                                                          |  |                                                                                              |  |                                                                                                                                            |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>4149</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arrhythmia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Ischemic Heart Disease</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5"</b><br><b>5"</b><br><b>3 years</b> |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                                            |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Hypertension</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                                            |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                                                              |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)               |  |                                                                                                                                            |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                         |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                               |  |                                                                                                                                            |  |                                                                                                                         |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>May 22</b> , 19 <b>80</b> , to <b>Sept 14</b> , 19 <b>82</b> , that (2) we last saw the deceased alive on <b>Aug 23</b> , 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)                                                                                                  |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                                            |  |                                                                                                                         |  |
| 22b. SIGNATURE<br><b>Lawrence E Klein MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                         |  | DEGREE<br><b>MD</b>                                                                                                                                         |  |                                                                                              |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>9/15/82</b>                                                                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lawrence E Klein MD</b>                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                         |  | 22e. ADDRESS<br><b>Harvey 502, Johns Hopkins Hosp 21205</b>                                                                                                 |  |                                                                                              |  |                                                                                                                                            |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                         |  | 23b. DATE<br><b>9/18/82</b>                                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b>                              |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore- Md.</b>                                                                           |  |                                                                                                                         |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm. C. March F/H 1101 E. North Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                         |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 17 1982</b>                                                                                                         |  |                                                                                              |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canfield</b>                                                                                      |  |                                                                                                                         |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                      |  |  |                                                                                                                                        |  |                                                                                                                                                             |                                                                                |                                |                                                                                      |  | 8 2 2 3 6 3 0<br>REG. NO.                                                                                                             |                                   |                                                                                          |  |                                                |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------|--------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|------------------------------------------------------------------------------------------|--|------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                    |  |  |                                                                                                                                        |  |                                                                                                                                                             |                                                                                |                                |                                                                                      |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                      |                                   |                                                                                          |  | 2b. HOUR                                       |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>Shaw WOODS                                                                                                                                                                                                                                                                                          |  |  |                                                                                                                                        |  |                                                                                                                                                             |                                                                                |                                |                                                                                      |  | September 20, 1982                                                                                                                    |                                   |                                                                                          |  | 6:09p M                                        |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                            |  |  | 4. RACE<br>Black                                                                                                                       |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>9 7 10                                                                                                                   |                                                                                |                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.                                           |  | IF UNDER 1 YEAR MONTHS DAYS                                                                                                           |                                   | IF UNDER 24 HRS. HOURS MIN.                                                              |  |                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.                                                                                                                                                                                                                                                                                         |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                    |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |                                                                                                                                       |                                   |                                                                                          |  |                                                |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                    |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |  |                                                                                                                                                             |                                                                                |                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  |                                                                                                                                       | 12b. KIND OF BUSINESS OR INDUSTRY |                                                                                          |  |                                                |  |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                         |  |  |                                                                                                                                        |  |                                                                                                                                                             |                                                                                |                                |                                                                                      |  | 13b. COUNTY<br>Balto.                                                                                                                 |                                   | 13c. CITY OR TOWN<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br>727 Druid Park Lake Dr. |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William Woods                                                                                                                                                                                                                                                                                      |  |  |                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Janie                                                                                                         |                                                                                |                                |                                                                                      |  | 16. ADDRESS                                                                                                                           |                                   |                                                                                          |  |                                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) No                                                                                                                                                                                                                                                                   |  |  |                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>241-10-1726                                                                                      |                                                                                | 17. INFORMANT<br>Mariam Sydnor |                                                                                      |  |                                                                                                                                       |                                   | 2435 Lakeview Avenue                                                                     |  |                                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Aspiration Pneumonia<br>5070<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |                                                                                                                                        |  |                                                                                                                                                             |                                                                                |                                |                                                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                          |                                   |                                                                                          |  |                                                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                        |  |  |                                                                                                                                        |  |                                                                                                                                                             |                                                                                |                                |                                                                                      |  |                                                                                                                                       |                                   |                                                                                          |  |                                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                    |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |  |                                                                                                                                                             |                                                                                |                                | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |                                                                                          |  |                                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                             |  |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                |                                                                                      |  |                                                                                                                                       |                                   |                                                                                          |  |                                                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                              |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                 |  |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                |                                                                                      |  |                                                                                                                                       |                                   |                                                                                          |  |                                                |  |
| 22a. I certify that (this hospital) attended the deceased from September 9, 1982, to September 20, 1982, that (we) lost saw the deceased alive on September 20, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.                    |  |  |                                                                                                                                        |  |                                                                                                                                                             |                                                                                |                                |                                                                                      |  |                                                                                                                                       |                                   |                                                                                          |  |                                                |  |
| 22b. SIGNATURE<br>Sepehr Soltani                                                                                                                                                                                                                                                                                                          |  |  |                                                                                                                                        |  | DEGREE<br>MD<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |                                                                                |                                |                                                                                      |  | 22c. DATE SIGNED<br>9/21/82                                                                                                           |                                   |                                                                                          |  |                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Sepehr Soltani, M.D.                                                                                                                                                                                                                                                                             |  |  |                                                                                                                                        |  | 22e. ADDRESS<br>c/o Maryland General Hospital                                                                                                               |                                                                                |                                |                                                                                      |  |                                                                                                                                       |                                   |                                                                                          |  |                                                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                    |  |  | 23b. DATE<br>9/25/82                                                                                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Eastview Mem. Pk.                                                                                                     |                                                                                |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                          |  | 25a. DATE OF INTERMENT BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>SEP 24 1982 [Signature]                                             |                                   |                                                                                          |  |                                                |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm C March F/H, Inc. 1101 E. North Ave.                                                                                                                                                                                                                                                           |  |  |                                                                                                                                        |  |                                                                                                                                                             |                                                                                |                                |                                                                                      |  |                                                                                                                                       |                                   |                                                                                          |  |                                                |  |

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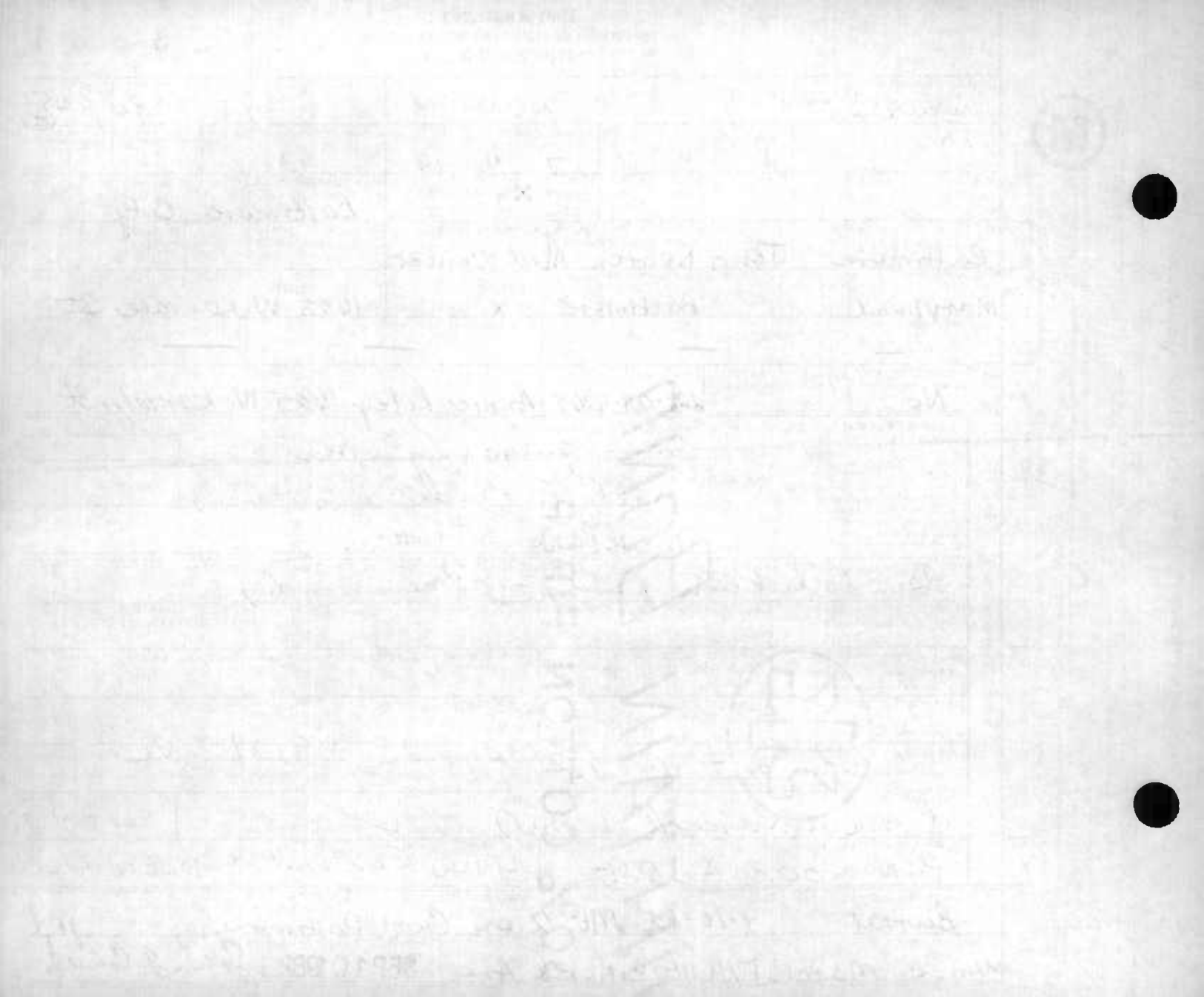
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185 | 186 | 187 | 188 | 189 | 190 | 191 | 192 | 193 | 194 | 195 | 196 | 197 | 198 | 199 | 200 | 201 | 202 | 203 | 204 | 205 | 206 | 207 | 208 | 209 | 210 | 211 | 212 | 213 | 214 | 215 | 216 | 217 | 218 | 219 | 220 | 221 | 222 | 223 | 224 | 225 | 226 | 227 | 228 | 229 | 230 | 231 | 232 | 233 | 234 | 235 | 236 | 237 | 238 | 239 | 240 | 241 | 242 | 243 | 244 | 245 | 246 | 247 | 248 | 249 | 250 | 251 | 252 | 253 | 254 | 255 | 256 | 257 | 258 | 259 | 260 | 261 | 262 | 263 | 264 | 265 | 266 | 267 | 268 | 269 | 270 | 271 | 272 | 273 | 274 | 275 | 276 | 277 | 278 | 279 | 280 | 281 | 282 | 283 | 284 | 285 | 286 | 287 | 288 | 289 | 290 | 291 | 292 | 293 | 294 | 295 | 296 | 297 | 298 | 299 | 300 | 301 | 302 | 303 | 304 | 305 | 306 | 307 | 308 | 309 | 310 | 311 | 312 | 313 | 314 | 315 | 316 | 317 | 318 | 319 | 320 | 321 | 322 | 323 | 324 | 325 | 326 | 327 | 328 | 329 | 330 | 331 | 332 | 333 | 334 | 335 | 336 | 337 | 338 | 339 | 340 | 341 | 342 | 343 | 344 | 345 | 346 | 347 | 348 | 349 | 350 | 351 | 352 | 353 | 354 | 355 | 356 | 357 | 358 | 359 | 360 | 361 | 362 | 363 | 364 | 365 | 366 | 367 | 368 | 369 | 370 | 371 | 372 | 373 | 374 | 375 | 376 | 377 | 378 | 379 | 380 | 381 | 382 | 383 | 384 | 385 | 386 | 387 | 388 | 389 | 390 | 391 | 392 | 393 | 394 | 395 | 396 | 397 | 398 | 399 | 400 | 401 | 402 | 403 | 404 | 405 | 406 | 407 | 408 | 409 | 410 | 411 | 412 | 413 | 414 | 415 | 416 | 417 | 418 | 419 | 420 | 421 | 422 | 423 | 424 | 425 | 426 | 427 | 428 | 429 | 430 | 431 | 432 | 433 | 434 | 435 | 436 | 437 | 438 | 439 | 440 | 441 | 442 | 443 | 444 | 445 | 446 | 447 | 448 | 449 | 450 | 451 | 452 | 453 | 454 | 455 | 456 | 457 | 458 | 459 | 460 | 461 | 462 | 463 | 464 | 465 | 466 | 467 | 468 | 469 | 470 | 471 | 472 | 473 | 474 | 475 | 476 | 477 | 478 | 479 | 480 | 481 | 482 | 483 | 484 | 485 | 486 | 487 | 488 | 489 | 490 | 491 | 492 | 493 | 494 | 495 | 496 | 497 | 498 | 499 | 500 | 501 | 502 | 503 | 504 | 505 | 506 | 507 | 508 | 509 | 510 | 511 | 512 | 513 | 514 | 515 | 516 | 517 | 518 | 519 | 520 | 521 | 522 | 523 | 524 | 525 | 526 | 527 | 528 | 529 | 530 | 531 | 532 | 533 | 534 | 535 | 536 | 537 | 538 | 539 | 540 | 541 | 542 | 543 | 544 | 545 | 546 | 547 | 548 | 549 | 550 | 551 | 552 | 553 | 554 | 555 | 556 | 557 | 558 | 559 | 560 | 561 | 562 | 563 | 564 | 565 | 566 | 567 | 568 | 569 | 570 | 571 | 572 | 573 | 574 | 575 | 576 | 577 | 578 | 579 | 580 | 581 | 582 | 583 | 584 | 585 | 586 | 587 | 588 | 589 | 590 | 591 | 592 | 593 | 594 | 595 | 596 | 597 | 598 | 599 | 600 | 601 | 602 | 603 | 604 | 605 | 606 | 607 | 608 | 609 | 610 | 611 | 612 | 613 | 614 | 615 | 616 | 617 | 618 | 619 | 620 | 621 | 622 | 623 | 624 | 625 | 626 | 627 | 628 | 629 | 630 | 631 | 632 | 633 | 634 | 635 | 636 | 637 | 638 | 639 | 640 | 641 | 642 | 643 | 644 | 645 | 646 | 647 | 648 | 649 | 650 | 651 | 652 | 653 | 654 | 655 | 656 | 657 | 658 | 659 | 660 | 661 | 662 | 663 | 664 | 665 | 666 | 667 | 668 | 669 | 670 | 671 | 672 | 673 | 674 | 675 | 676 | 677 | 678 | 679 | 680 | 681 | 682 | 683 | 684 | 685 | 686 | 687 | 688 | 689 | 690 | 691 | 692 | 693 | 694 | 695 | 696 | 697 | 698 | 699 | 700 | 701 | 702 | 703 | 704 | 705 | 706 | 707 | 708 | 709 | 710 | 711 | 712 | 713 | 714 | 715 | 716 | 717 | 718 | 719 | 720 | 721 | 722 | 723 | 724 | 725 | 726 | 727 | 728 | 729 | 730 | 731 | 732 | 733 | 734 | 735 | 736 | 737 | 738 | 739 | 740 | 741 | 742 | 743 | 744 | 745 | 746 | 747 | 748 | 749 | 750 | 751 | 752 | 753 | 754 | 755 | 756 | 757 | 758 | 759 | 760 | 761 | 762 | 763 | 764 | 765 | 766 | 767 | 768 | 769 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 780 | 781 | 782 | 783 | 784 | 785 | 786 | 787 | 788 | 789 | 790 | 791 | 792 | 793 | 794 | 795 | 796 | 797 | 798 | 799 | 800 | 801 | 802 | 803 | 804 | 805 | 806 | 807 | 808 | 809 | 810 | 811 | 812 | 813 | 814 | 815 | 816 | 817 | 818 | 819 | 820 | 821 | 822 | 823 | 824 | 825 | 826 | 827 | 828 | 829 | 830 | 831 | 832 | 833 | 834 | 835 | 836 | 837 | 838 | 839 | 840 | 841 | 842 | 843 | 844 | 845 | 846 | 847 | 848 | 849 | 850 | 851 | 852 | 853 | 854 | 855 | 856 | 857 | 858 | 859 | 860 | 861 | 862 | 863 | 864 | 865 | 866 | 867 | 868 | 869 | 870 | 871 | 872 | 873 | 874 | 875 | 876 | 877 | 878 | 879 | 880 | 881 | 882 | 883 | 884 | 885 | 886 | 887 | 888 | 889 | 890 | 891 | 892 | 893 | 894 | 895 | 896 | 897 | 898 | 899 | 900 | 901 | 902 | 903 | 904 | 905 | 906 | 907 | 908 | 909 | 910 | 911 | 912 | 913 | 914 | 915 | 916 | 917 | 918 | 919 | 920 | 921 | 922 | 923 | 924 | 925 | 926 | 927 | 928 | 929 | 930 | 931 | 932 | 933 | 934 | 935 | 936 | 937 | 938 | 939 | 940 | 941 | 942 | 943 | 944 | 945 | 946 | 947 | 948 | 949 | 950 | 951 | 952 | 953 | 954 | 955 | 956 | 957 | 958 | 959 | 960 | 961 | 962 | 963 | 964 | 965 | 966 | 967 | 968 | 969 | 970 | 971 | 972 | 973 | 974 | 975 | 976 | 977 | 978 | 979 | 980 | 981 | 982 | 983 | 984 | 985 | 986 | 987 | 988 | 989 | 990 | 991 | 992 | 993 | 994 | 995 | 996 | 997 | 998 | 999 | 1000 | 1001 | 1002 | 1003 | 1004 | 1005 | 1006 | 1007 | 1008 | 1009 | 1010 | 1011 | 1012 | 1013 | 1014 | 1015 | 1016 | 1017 | 1018 | 1019 | 1020 | 1021 | 1022 | 1023 | 1024 | 1025 | 1026 | 1027 | 1028 | 1029 | 1030 | 1031 | 1032 | 1033 | 1034 | 1035 | 1036 | 1037 | 1038 | 1039 | 1040 | 1041 | 1042 | 1043 | 1044 | 1045 | 1046 | 1047 | 1048 | 1049 | 1050 | 1051 | 1052 | 1053 | 1054 | 1055 | 1056 | 1057 | 1058 | 1059 | 1060 | 1061 | 1062 | 1063 | 1064 | 1065 | 1066 | 1067 | 1068 | 1069 | 1070 | 1071 | 1072 | 1073 | 1074 | 1075 | 1076 | 1077 | 1078 | 1079 | 1080 | 1081 | 1082 | 1083 | 1084 | 1085 | 1086 | 1087 | 1088 | 1089 | 1090 | 1091 | 1092 | 1093 | 1094 | 1095 | 1096 | 1097 | 1098 | 1099 | 1100 | 1101 | 1102 | 1103 | 1104 | 1105 | 1106 | 1107 | 1108 | 1109 | 1110 | 1111 | 1112 | 1113 | 1114 | 1115 | 1116 | 1117 | 1118 | 1119 | 1120 | 1121 | 1122 | 1123 | 1124 | 1125 | 1126 | 1127 | 1128 | 1129 | 1130 | 1131 | 1132 | 1133 | 1134 | 1135 | 1136 | 1137 | 1138 | 1139 | 1140 | 1141 | 1142 | 1143 | 1144 | 1145 | 1146 | 1147 | 1148 | 1149 | 1150 | 1151 | 1152 | 1153 | 1154 | 1155 | 1156 | 1157 | 1158 | 1159 | 1160 | 1161 | 1162 | 1163 | 1164 | 1165 | 1166 | 1167 | 1168 | 1169 | 1170 | 1171 | 1172 | 1173 | 1174 | 1175 | 1176 | 1177 | 1178 | 1179 | 1180 | 1181 | 1182 | 1183 | 1184 | 1185 | 1186 | 1187 | 1188 | 1189 | 1190 | 1191 | 1192 | 1193 | 1194 | 1195 | 1196 | 1197 | 1198 | 1199 | 1200 | 1201 | 1202 | 1203 | 1204 | 1205 | 1206 | 1207 | 1208 | 1209 | 1210 | 1211 | 1212 | 1213 | 1214 | 1215 | 1216 | 1217 | 1218 | 1219 | 1220 | 1221 | 1222 | 1223 | 1224 | 1225 | 1226 | 1227 | 1228 | 1229 | 1230 | 1231 | 1232 | 1233 | 1234 | 1235 | 1236 | 1237 | 1238 | 1239 | 1240 | 1241 | 1242 | 1243 | 1244 | 1245 | 1246 | 1247 | 1248 | 1249 | 1250 | 1251 | 1252 | 1253 | 1254 | 1255 | 1256 | 1257 | 1258 | 1259 | 1260 | 1261 | 1262 | 1263 | 1264 | 1265 | 1266 | 1267 | 1268 | 1269 | 1270 | 1271 | 1272 | 1273 | 1274 | 1275 | 1276 | 1277 | 1278 | 1279 | 1280 | 1281 | 1282 | 1283 | 1284 | 1285 | 1286 | 1287 | 1288 | 1289 | 1290 | 1291 | 1292 | 1293 | 1294 | 1295 | 1296 | 1297 | 1298 | 1299 | 1300 | 1301 | 1302 | 1303 | 1304 | 1305 | 1306 | 1307 | 1308 | 1309 | 1310 | 1311 | 1312 | 1313 | 1314 | 1315 | 1316 | 1317 | 1318 | 1319 | 1320 | 1321 | 1322 | 1323 | 1324 | 1325 | 1326 | 1327 | 1328 | 1329 | 1330 | 1331 | 1332 | 1333 | 1334 | 1335 | 1336 | 1337 | 1338 | 1339 | 1340 | 1341 | 1342 | 1343 | 1344 | 1345 | 1346 | 1347 | 1348 | 1349 | 1350 | 1351 | 1352 | 1353 | 1354 | 1355 | 1356 | 1357 | 1358 | 1359 | 1360 | 1361 | 1362 | 1363 | 1364 | 1365 | 1366 | 1367 | 1368 | 1369 | 1370 | 1371 | 1372 | 1373 | 1374 | 1375 | 1376 | 1377 | 1378 | 1379 | 1380 | 1381 | 1382 | 1383 | 1384 | 1385 | 1386 | 1387 | 1388 | 1389 | 1390 | 1391 | 1392 | 1393 | 1394 | 1395 | 1396 | 1397 | 1398 | 1399 | 1400 | 1401 | 1402 | 1403 | 1404 | 1405 | 1406 | 1407 | 1408 | 1409 | 1410 | 1411 | 1412 | 1413 | 1414 | 1415 | 1416 | 1417 | 1418 | 1419 | 1420 | 1421 | 1422 | 1423 | 1424 | 1425 | 1426 | 1427 | 1428 | 1429 | 1430 | 1431 | 1432 | 1433 | 1434 | 1435 | 1436 | 1437 | 1438 | 1439 | 1440 | 1441 | 1442 | 1443 | 1444 | 1445 | 1446 | 1447 | 1448 | 1449 | 1450 | 1451 | 1452 | 1453 | 1454 | 1455 | 1456 | 1457 | 1458 | 1459 | 1460 | 1461 | 1462 | 1463 | 1464 | 1465 | 1466 | 1467 | 1468 | 1469 | 1470 | 1471 | 1472 | 1473 | 1474 | 1475 | 1476 | 1477 | 1478 | 1479 | 1480 | 1481 | 1482 | 1483 | 1484</ |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                     |  |                                              |                                                                                                                                                             |  |                                                            |                                                                                |                                                                                                 | 8 2 2 3 6 3 1<br>REG. NO.                                                                                                                  |  |                                                                                                                               |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>WOODROW WOODSON                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                     |  |                                              | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Sept 7 1982                                                                                                          |  |                                                            |                                                                                |                                                                                                 | 2b. HOUR<br>8:45 AM                                                                                                                        |  |                                                                                                                               |  |
| 3. SEX<br>M                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br>B                                                                                                                        |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 4 19 |                                                                                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.                 |                                                                                |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                                  |  |                                                                                                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>✓                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br>✓                                                                                                   |  |                                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |                                                                                                 |                                                                                                                                            |  |                                                                                                                               |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>John Seaton Med Center |  |                                              |                                                                                                                                                             |  |                                                            |                                                                                |                                                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                             |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                     |  |                                              | 13b. COUNTY                                                                                                                                                 |  | 13c. CITY OR TOWN<br>Baltimore                             |                                                                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                            |  | 13e. STREET ADDRESS<br>1623 W. Lanvale St                                                                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                     |  |                                              | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                                                                               |  |                                                            |                                                                                |                                                                                                 |                                                                                                                                            |  |                                                                                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                     |  |                                              | 16b. SOCIAL SECURITY NO.<br>228-03-9767                                                                                                                     |  | 17. INFORMANT<br>ADDRESS<br>Annie Riley 1625 W. Lanvale St |                                                                                |                                                                                                 |                                                                                                                                            |  |                                                                                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4360 Cardio pulmonary arrest.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Multiple pressure wounds<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Multiple strokes.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>Pseudo bulbar palsy - pneumonia |  |                                                                                                                                     |  |                                              |                                                                                                                                                             |  |                                                            |                                                                                |                                                                                                 | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                                            |  |                                                                                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                     |  |                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                            |                                                                                |                                                                                                 | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                     |  |                                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |  |                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                                                                                                 |                                                                                                                                            |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                     |  |                                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  |                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                 |                                                                                                                                            |  |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/30 19 82 to 9/7/ 19 82 that (I) (we) lost<br>saw the deceased alive on Sept 7 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                  |  |                                                                                                                                     |  |                                              |                                                                                                                                                             |  |                                                            |                                                                                |                                                                                                 |                                                                                                                                            |  |                                                                                                                               |  |
| 22b. SIGNATURE<br>P. NIKOOMANESH                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                     |  |                                              | DEGREE<br>MD                                                                                                                                                |  |                                                            |                                                                                |                                                                                                 | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>Sept 7 1982                                                                                               |  |
| 22d. PHYSICIAN'S NAME, (TYPE OR PRINT)<br>P. NIKOOMANESH                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                     |  |                                              | 22e. ADDRESS<br>4940 Eastern Ave Balto 21224                                                                                                                |  |                                                            |                                                                                |                                                                                                 |                                                                                                                                            |  |                                                                                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                     |  |                                              | 23b. DATE<br>9-10-82                                                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt Zion Cem          |                                                                                |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md                                                                                |  |                                                                                                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 11012 North Ave                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                     |  |                                              | 25a. DATE REC'D. BY REGISTRAR<br>SEP 10 1982                                                                                                                |  |                                                            | 25b. REGISTRAR'S SIGNATURE<br>John J. Conish                                   |                                                                                                 |                                                                                                                                            |  |                                                                                                                               |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                  |  |                  |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                               |  | REG. NO. 2 2 3 6 3 2                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Hubert Clyde Woolridge                                                                                                                                                                                                                                                                                                                                                          |  |                  |  |                                                                                                                                  |  | 2a. DATE KNOWN OF DEATH<br>XX MONTH DAY YEAR<br>9 20 19 82                                                                                                  |  | 2b. HOUR<br>M<br>11:40 a.m.                                                   |  |                                                                                                 |  |
| 3. SEX<br>W MALE                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br>WHITE |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2/24/1921                                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS.                                                                                                                  |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.                                         |  | 7c. DATE PRONOUNCED DEAD<br>9 20 19 82                                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA                                                                                                                                                                                                                                                                                                                                                                                    |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                   |  |                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>TRUCK DRIVER |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>INDEPENDENT                                                |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                  |  |                                                                                                                                  |  | 13b. COUNTY<br>ANNE ARUNDEL                                                                                                                                 |  | 13c. CITY OR TOWN<br>LINTHICUM                                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>LACY                                                                                                                                                                                                                                                                                                                                                                                           |  |                  |  |                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SUE DALTON                                                                                                 |  | 13e. STREET ADDRESS<br>1604 NURSERY RD. 21090                                 |  |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                              |  |                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214.16.3187                                                           |  | 17. INFORMANT<br>ADDRESS<br>219 HOLLINS ST.<br>RICHARD J. WOOLRIDGE BALTO., MD. 21223                                                                       |  |                                                                               |  |                                                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4292 Arteriosclerotic Cardiovascular Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                             |  |                  |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                               |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                      |  |                  |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                               |  |                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                |  |                                                                                                                                                             |  |                                                                               |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                   |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                               |  |                                                                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                           |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                               |  |                                                                                                 |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                               |  |                                                                                                 |  |
| ACTUAL SIGNATURE<br>Dennis F. Smyth, M.D.                                                                                                                                                                                                                                                                                                                                                                                                |  |                  |  | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER                                                                                    |  |                                                                                                                                                             |  | DATE SIGNED<br>9-20-82                                                        |  |                                                                                                 |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Dennis F. Smyth, M.D.                                                                                                                                                                                                                                                                                                                                                                              |  |                  |  | ADDRESS<br>111 Penn Street                                                                                                       |  |                                                                                                                                                             |  |                                                                               |  |                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>CREMATION                                                                                                                                                                                                                                                                                                                                                                                |  |                  |  | 23b. DATE<br>9/22/1982                                                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GREEN MOUNT                                                                                                           |  |                                                                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD.                                        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222                                                                                                                                                                                                                                                                                                                                                           |  |                  |  |                                                                                                                                  |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 23 1982                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Carver                                  |  |                                                                                                 |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

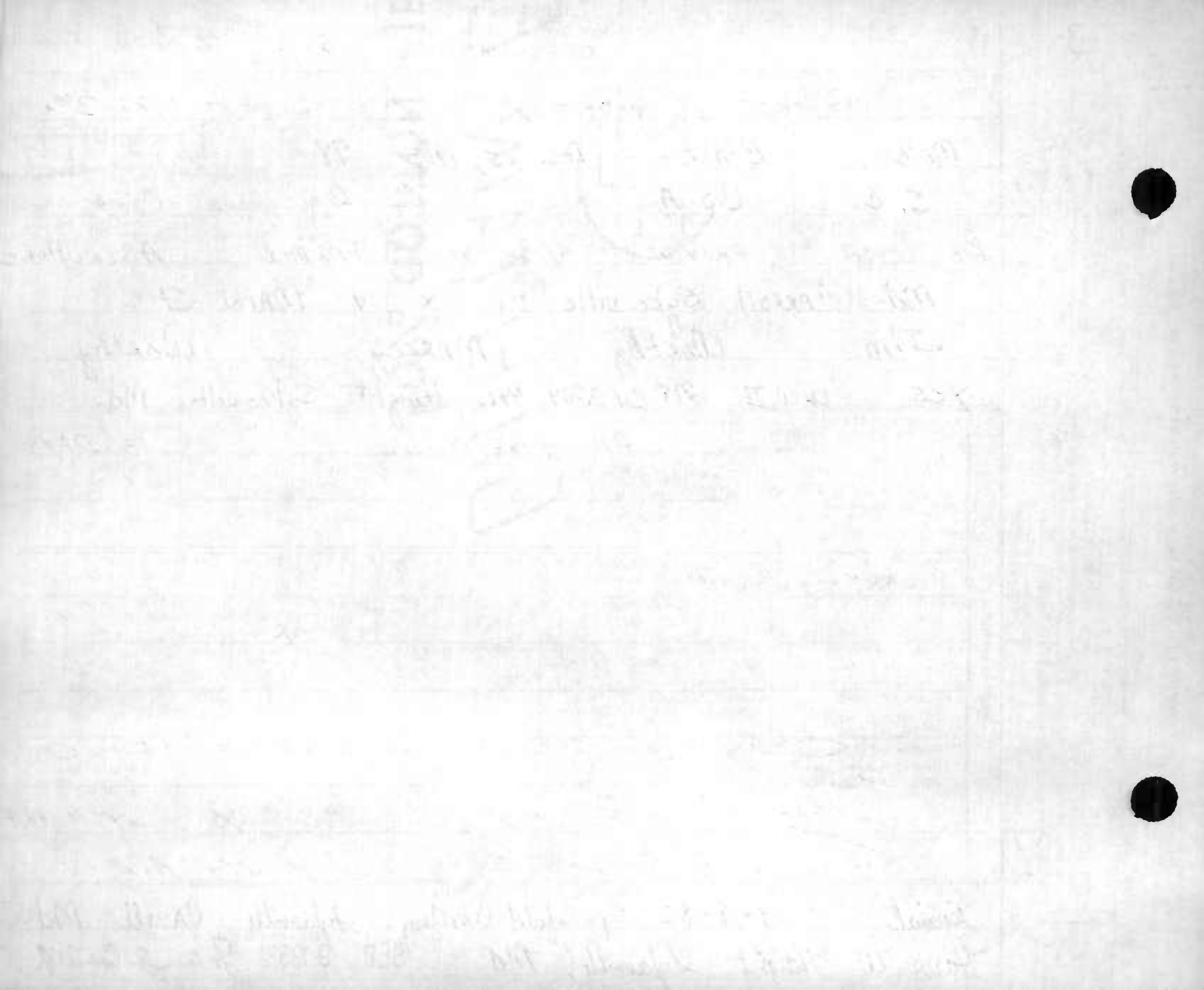
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                        |  |                                                                                                                                        |                                                                        |                                                            |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                                                       |                                                                                                                            | REG. NO. 8 2 2 3 6 3 3                                        |  |                                                         |  |  |                              |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|--|---------------------------------------------------------|--|--|------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                        |                                                                        |                                                            | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GEORGE WORTHY</b>                                                                                                    |                                                                                                 |                                                                                      |                                                                                                                                                       |                                                                                                                            |                                                               |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>SEPT 4, 1982</b> |  |  | 2b. HOUR<br><b>3:05 a.m.</b> |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br><b>Black</b>                                                                                                                |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 15, 1903</b> |                                                                                                                                                             |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.                                    |                                                                                                                                                       |                                                                                                                            | IF UNDER 1 YEAR<br>MONTHS DAYS                                |  | IF UNDER 24 HRS.<br>HOURS MIN.                          |  |  |                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. C.</b>                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S. A.</b>                                                                                         |                                                                        |                                                            | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                                                     |                                                                                                                            |                                                               |  |                                                         |  |  |                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PROVIDENT HOSPITAL</b> |                                                                        |                                                            |                                                                                                                                                             |                                                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>FARMER</b>    |                                                                                                                                                       |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AGRICULTURE</b>       |  |                                                         |  |  |                              |  |
| 13a. STATE<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                    |  | 13b. CITY OR TOWN<br><b>CARROLL</b>                                                                                                    |                                                                        | 13c. CITY OR TOWN<br><b>Sykesville</b>                     |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                      | 13e. STREET ADDRESS<br><b>1 MAIN ST.</b>                                                                                                              |                                                                                                                            |                                                               |  |                                                         |  |  |                              |  |
| 14. FATHER'S NAME<br><b>Jim</b>                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                        |                                                                        |                                                            | 15. MOTHER'S MAIDEN NAME<br><b>MARCEY</b>                                                                                                                   |                                                                                                 |                                                                                      |                                                                                                                                                       |                                                                                                                            | 15. ADDRESS<br><b>Worthy</b>                                  |  |                                                         |  |  |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>                                                                                                                                                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.<br><b>WW II</b>                                                                                               |                                                                        | 17. INFORMANT<br><b>Harry Haight</b>                       |                                                                                                                                                             | 17. ADDRESS<br><b>Sykesville, Md.</b>                                                           |                                                                                      |                                                                                                                                                       |                                                                                                                            |                                                               |  |                                                         |  |  |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PNEUMONIA</b><br><b>4860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.            |  |                                                                                                                                        |                                                                        |                                                            |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                                                       |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 DAYS</b> |  |                                                         |  |  |                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).<br><b>CACHEXIA, DEHYDRATION</b>                                                                                                                                                                                                         |  |                                                                                                                                        |                                                                        |                                                            |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                                                       |                                                                                                                            |                                                               |  |                                                         |  |  |                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                            |                                                                                                                                                             |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                               |  |                                                         |  |  |                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                    |  |                                                                                                                                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                                                                 |                                                                                      |                                                                                                                                                       |                                                                                                                            |                                                               |  |                                                         |  |  |                              |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                   |  |                                                                                                                                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                                 |                                                                                      |                                                                                                                                                       |                                                                                                                            |                                                               |  |                                                         |  |  |                              |  |
| 22a. I certify that (I) <u>did</u> attend the deceased from <u>SEPT 3</u> , 19 <u>82</u> , to <u>SEPT 4</u> , 19 <u>82</u> , that (I) <u>we</u> last saw the deceased alive on <u>SEPT 4</u> , 19 <u>82</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death. |  |                                                                                                                                        |                                                                        |                                                            |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                                                                                                       |                                                                                                                            |                                                               |  |                                                         |  |  |                              |  |
| 22b. SIGNATURE<br><b>Irving A. Cohen</b>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                        |                                                                        |                                                            | DEGREE<br><b>M.D.</b>                                                                                                                                       |                                                                                                 |                                                                                      | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                                            | 22c. DATE SIGNED<br><b>SEPT 4, 1982</b>                       |  |                                                         |  |  |                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>IRVING A. COHEN</b>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                        |                                                                        |                                                            | 22e. ADDRESS<br><b>2600 LIBERTY HTS AVE</b>                                                                                                                 |                                                                                                 |                                                                                      |                                                                                                                                                       |                                                                                                                            |                                                               |  |                                                         |  |  |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                        | 23b. DATE<br><b>9-8-82</b>                                             |                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Springfield Cemetery</b>                                                                                           |                                                                                                 |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sykesville Carroll Md.</b>                                                                           |                                                                                                                            |                                                               |  |                                                         |  |  |                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Harry W. Haight</b>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                        |                                                                        |                                                            | ADDRESS<br><b>Sykesville, Md.</b>                                                                                                                           |                                                                                                 | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 9 1982</b>                                   |                                                                                                                                                       | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                                                        |                                                               |  |                                                         |  |  |                              |  |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITALS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

31- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  |                                                                                                                                       |                                                                       |                                                                                                                                                             |                                                                                                      |                                                                                                 |                                                                                     |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>DAVID L. WRAY                                                                                                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                       | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>9 4 19 82                     |                                                                                                                                                             |                                                                                                      | 2b. HOUR<br>12:15 a M                                                                           |                                                                                     |                                              |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                           | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 6 63                                                                                         | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>18 YRS.                         | IF UNDER 1 YR.<br>MONTHS DAYS                                                                                                                               | IF UNDER 24 HRS.<br>HOURS MIN                                                                        | 2c. DATE PRONOUNCED DEAD<br>9 4 19 82                                                           |                                                                                     |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                    |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                   |                                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |                                                                                     |                                              |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital |                                                                       |                                                                                                                                                             |                                                                                                      | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |                                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                   |                  | 13b. COUNTY                                                                                                                           |                                                                       | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |                                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                     |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Robert L. Wray                                                                                                                                                                                                                                                                                                                                                                                 |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Helen Lea                                                                            |                                                                       | 13e. STREET ADDRESS<br>1813m Winford Road                                                                                                                   |                                                                                                      |                                                                                                 |                                                                                     |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>BNo                                                                                                                                                                                                                                                                                                                                                             |                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-80-5264                                                                |                                                                       | 17. INFORMANT<br>ADDRESS<br>Helen Thomas 1813 Winford Road                                                                                                  |                                                                                                      |                                                                                                 |                                                                                     |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>9654 IMMEDIATE CAUSE (a) Gunshot wound of chest (unspecified weapon)<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                          |                  |                                                                                                                                       |                                                                       |                                                                                                                                                             |                                                                                                      |                                                                                                 |                                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                       |                                                                       |                                                                                                                                                             |                                                                                                      |                                                                                                 |                                                                                     |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                     |                                                                                                                                                             |                                                                                                      |                                                                                                 | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                           |                  |                                                                                                                                       | 21b. TIME OF INJURY<br>HOUR MIN MONTH DAY YEAR<br>11:15m 9-3- 19 82   |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject shot.       |                                                                                                 |                                                                                     |                                              |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                       | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>1200 blk. E. Cold Spring Lane, Balto. City, Md. |                                                                                                 |                                                                                     |                                              |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |                                                                                                                                       |                                                                       |                                                                                                                                                             |                                                                                                      |                                                                                                 |                                                                                     |                                              |
| ACTUAL SIGNATURE<br>Ann M. Dixon, M.D.                                                                                                                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                       | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER                    |                                                                                                                                                             |                                                                                                      | DATE SIGNED<br>9-4-82                                                                           |                                                                                     |                                              |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Ann M. Dixon, M.D.                                                                                                                                                                                                                                                                                                                                                                                 |                  |                                                                                                                                       | ADDRESS<br>111 Penn St., Balto., Md. 21201                            |                                                                                                                                                             |                                                                                                      |                                                                                                 |                                                                                     |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                       | 23b. DATE<br>8/8/82                                                   |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cem                                                  |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                         |                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.                                                                                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                       | 25a. DATE REC'D. BY REGISTRAR<br>SEP 8 1982                           |                                                                                                                                                             |                                                                                                      | 25b. REGISTRAR'S SIGNATURE<br>John J. Lander                                                    |                                                                                     |                                              |

RECEIVED  
JAN 10 1900  
U.S. DEPT. OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B, there is any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/B1  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 6 3 5

REG. NO.

|                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                         |  |                                                                                                                                                                                                                                   |  |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                              |  | 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                     |  | 2a. DATE OF DEATH                                                                                                                                                                                                                 |  | 2b. HOUR                                                                                                                   |  |
|                                                                                                                                                                                                                                                                                                           |  | FIRST MIDDLE LAST<br>ARCHIE L. WRIGHT                                                                                                                                                   |  | MONTH DAY YEAR<br>9 2 82                                                                                                                                                                                                          |  | 12:55 PM                                                                                                                   |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                            |  | 4. RACE<br>NEGRO                                                                                                                                                                        |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 6 98                                                                                                                                                                                     |  | 6. AGE IN YEARS LAST BIRTHDAY<br>83 YRS.                                                                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Virginia                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br>US                                                                                                                                                      |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore city MD.                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hospital                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                                                                                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                          |  | 13b. COUNTY<br>US                                                                                                                                                                       |  | 13c. CITY OR TOWN                                                                                                                                                                                                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Willie Wright                                                                                                                                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Charlotte Oliver                                                                                                                       |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br>212 031645                                                                                     |  |
|                                                                                                                                                                                                                                                                                                           |  | 17. INFORMANT<br>ADDRESS<br>Vivian L. McClain 5813 Simmonds Avenue                                                                                                                      |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4100 IMMEDIATE CAUSE (a) ACUTE MASSIVE MYOCARDIAL INFARCT<br>(b) ASCVD. S/P MI<br>(c) DUE TO, OR AS A CONSEQUENCE OF |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| MEDICAL CERTIFICATION                                                                                                                                                                                                                                                                                     |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Pulmonary emboli? cord, DIC, unilateral edema RLE |  | 19a. DATE OF OPERATION                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                           |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                  |  | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                                              |  | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                    |  | 20d. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                  |  |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                              |  | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                  |  | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                 |  | 21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/2 19 82 to 9/2 19 82 that (I) (we) last saw the deceased alive on 9/2 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br>A. C. ENRIQUE                                                                                                                                                         |  | 22c. DATE SIGNED<br>MD                                                                                                                                                                                                            |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. C. ENRIQUE                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                    |  | 23b. DATE<br>9/7/82                                                                                                                                                                     |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt Auburn Cemetery                                                                                                                                                                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD                                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>William C. March F/H 1101 E. North Avenue                                                                                                                                                                                                                                 |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 8 1982                                                                                                                                             |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel                                                                                                                                                                                      |  |                                                                                                                            |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1- FOR  
STATE  
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 6 3 6  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                            |  |                                                                        |  |                                                                                              |  |                                                                                     |                                                     |                                                                                                                            |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Theora Wriston</b>                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                            |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>09 13 82</b>                  |  |                                                                                              |  | 2b HOUR<br><b>5:15 A.M.</b>                                                         |                                                     |                                                                                                                            |  |  |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 4 RACE<br><b>Caucasian</b>                                                                                                                 |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>03 07 1896</b>                 |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.                                             |  | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>                    |                                                     | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                               |  |  |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                           |  | 9 WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                            |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.          |  |                                                                                              |  |                                                                                     |                                                     |                                                                                                                            |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>City Hospital (Baltimore)</b> |  |                                                                        |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>          |  |                                                                                     | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b> |                                                                                                                            |  |  |
| 13a STATE<br><b>W. Va.</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                            |  | 13b COUNTY<br><b>Fayette</b>                                           |  | 13c CITY OR TOWN<br><b>Scarbro</b>                                                           |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                     | 13e STREET ADDRESS<br><b>Box 81 Rt#1 25917</b>                                                                             |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Squire Estep</b>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                            |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mahale Meadows</b> |  |                                                                                              |  |                                                                                     |                                                     |                                                                                                                            |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                            |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>None</b>  |  | 17. INFORMANT<br><b>George Wriston (Husband)</b>                                             |  |                                                                                     |                                                     | ADDRESS                                                                                                                    |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4100</b><br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction (</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>arteriosclerotic heart disease</b><br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |                                                                                                                                            |  |                                                                        |  |                                                                                              |  |                                                                                     |                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>sudden years</b>                                                        |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>none</b>                                                                                                                                                                                                                                                             |  |                                                                                                                                            |  |                                                                        |  |                                                                                              |  |                                                                                     |                                                     |                                                                                                                            |  |  |
| 19a DATE OF OPERATION<br><b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>N/A</b>         |  |                                                                                              |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                          |  |                                                                                                                                            |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>N/A 19</b>       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>N/A</b> |  |                                                                                     |                                                     |                                                                                                                            |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                            |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                            |  |                                                                                     |                                                     |                                                                                                                            |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>May 1982</b> to <b>8-30 1982</b> , that (I) (we) last saw the deceased alive on <b>8/30 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.                                                                                     |  |                                                                                                                                            |  |                                                                        |  |                                                                                              |  |                                                                                     |                                                     |                                                                                                                            |  |  |
| 22b. SIGNATURE OF ATTENDING PHYSICIAN<br><b>E. Barnes</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                            |  |                                                                        |  |                                                                                              |  |                                                                                     |                                                     | 22c. DATE SIGNED<br><b>9/9/82</b>                                                                                          |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W/E. Baermann, M.D.</b>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                            |  |                                                                        |  | 22e. ADDRESS<br><b>100 N. Broadway, Balto., Md. 21231</b>                                    |  |                                                                                     |                                                     |                                                                                                                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                            |  | 23b. DATE<br><b>9/16/82</b>                                            |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>High Lawn Mem. Pk.</b>                              |  |                                                                                     |                                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Oak Hill Fayette W. Va.</b>                                               |  |  |
| 24. FUNERAL DIRECTOR'S NAME<br><b>E. Barnes</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                            |  |                                                                        |  | 24b. ADDRESS<br><b>Fleming Funeral Service- Benson, Md.</b>                                  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 20 1982</b>                                 |                                                     | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Carver</i>                                                                        |  |  |

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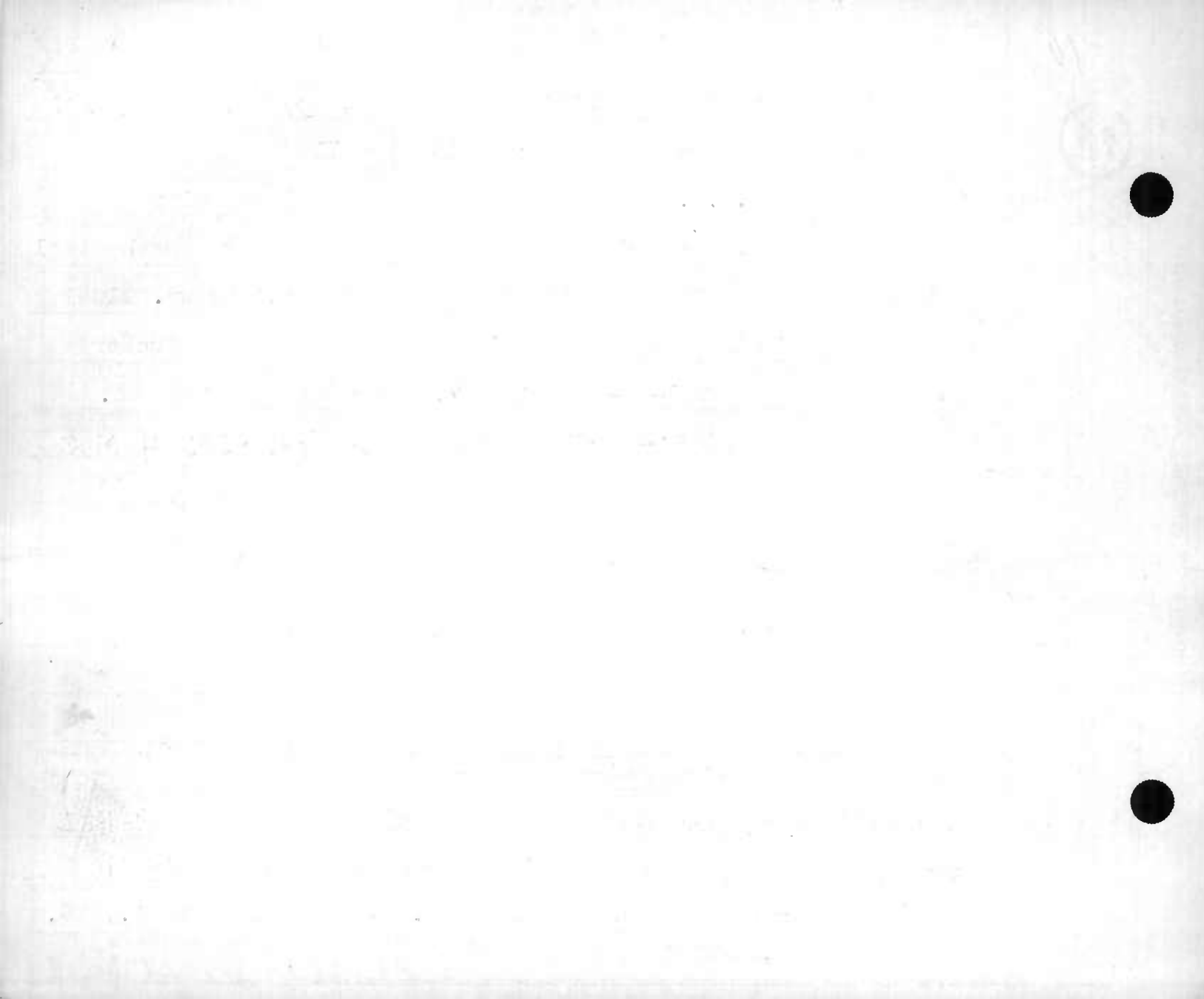
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                  |  |                                                                                  |                                                  |                                                                                                                                                             |                                                                                     |                                                                            |                                                                                                          |                                                      |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                |  | 8 2                                                                              |                                                  | 2 3 6 3 7                                                                                                                                                   |                                                                                     | REG. NO.                                                                   |                                                                                                          |                                                      |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Leo Oscar Wyche</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                  | 2. DATE OF DEATH<br><b>SEPTEMBER 9-01-82</b>     |                                                                                                                                                             |                                                                                     | 7b. HOUR<br><b>12 25 PM</b>                                                |                                                                                                          |                                                      |  |
| 3 SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  | 4 RACE<br><b>Negro</b>                                                           |                                                  | 5. DATE OF BIRTH<br><b>May 10 1911</b>                                                                                                                      |                                                                                     | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b>                                |                                                                                                          | 7a. IF UNDER 1 YEAR<br>MONTHS DAYS                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                    |                                                  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |                                                                                     | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>               |                                                                                                          | MD.                                                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>Mercy Hospital</b> |                                                  |                                                                                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Steelworker</b> |                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth Steel</b>                                                   |                                                      |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY<br><b>H.A.</b>                                                       |                                                  | 13c. CITY OR TOWN<br><b>Glen Burnie</b>                                                                                                                     |                                                                                     | 13d. INSIDE CITY LIMITS?<br><b>YES</b> NO <input type="checkbox"/>         |                                                                                                          | 13e. STREET ADDRESS<br><b>203 Warfield Rd. 21061</b> |  |
| 14 FATHER'S NAME<br><b>John Benjamin Wyche</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                  | 15 MOTHER'S MAIDEN NAME<br><b>Matilda Tucker</b> |                                                                                                                                                             |                                                                                     |                                                                            |                                                                                                          |                                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br><b>213-07-9877</b>                                   |                                                  | 17 INFORMANT<br><b>Ruth W. Wyche</b>                                                                                                                        |                                                                                     | ADDRESS<br><b>21061 203 Warfield Rd.</b>                                   |                                                                                                          |                                                      |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1579 IMMEDIATE CAUSE (a) METASTATIC CANCER OF PANCREAS 4 MDS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 MDS</b> |  |                                                                                  |                                                  |                                                                                                                                                             |                                                                                     |                                                                            |                                                                                                          |                                                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                    |  |                                                                                  |                                                  |                                                                                                                                                             |                                                                                     |                                                                            |                                                                                                          |                                                      |  |
| 19a. DATE OF OPERATION<br><b>6-8-82</b>                                                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>OBSTRUCTIVE JAUNDICE</b>  |                                                  |                                                                                                                                                             | 20a. AUTOPSY?<br><b>YES</b> NO <input checked="" type="checkbox"/>                  |                                                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> NO <input type="checkbox"/> |                                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                |                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                     |                                                                            |                                                                                                          |                                                      |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)           |                                                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                     |                                                                            |                                                                                                          |                                                      |  |
| 22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>1-10</b> , 19 <b>75</b> , to <b>9-1</b> , 19 <b>82</b> , that (I) <del>(was)</del> lost saw the deceased alive on <b>7-15</b> , 19 <b>82</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did not) view the body after death.               |  |                                                                                  |                                                  |                                                                                                                                                             |                                                                                     |                                                                            |                                                                                                          |                                                      |  |
| 22b. SIGNATURE<br><b>Barnett Berman, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                  |                                                  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                     | 22c. DATE SIGNED<br><b>9-1-82</b>                                          |                                                                                                          |                                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BARNETT BERMAN, M.D.</b>                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                  |                                                  | 22e. ADDRESS<br><b>611 PARK AVE. BALTIMORE, MD 21201</b>                                                                                                    |                                                                                     |                                                                            |                                                                                                          |                                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                            |  | 23b. DATE<br><b>09/04/1982</b>                                                   |                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL CEM.</b>                                                                                                |                                                                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE BALTO., MD.</b> |                                                                                                          |                                                      |  |
| 24 FUNERAL DIRECTOR<br><b>MARSHALL W JONES, JR/4101</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                  |                                                  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 3 1982</b>                                                                                                          |                                                                                     | 25b. REGISTRAR'S SIGNATURE<br><b>Jan J. Carver</b>                         |                                                                                                          |                                                      |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                       |  |                                                                                                                                                          |  |                                                                                                 |  |                                                                                              |  | REG. NO. 2 2 3 6 3 8                                                               |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                       |  |                                                                                                                                                          |  |                                                                                                 |  |                                                                                              |  |                                                                                    |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>RONALD JOHN YANCHESKI                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                       |  |                                                                                                                                                          |  |                                                                                                 |  |                                                                                              |  | 7a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> 9-27-82 19 |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br>White                                                                                                                      |  | 5. DATE OF BIRTH (MONTH DAY YEAR)<br>11-8-1945                                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>36 YRS.                                                      |  | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN                                                       |  | 7b. HOUR<br>M                                                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.                                                                                                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City                                          |  | 2c. DATE PRONOUNCED DEAD<br>9-27-82 19                                                       |  | 7d. HOUR<br>7:52 PM                                                                |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital S.T.U. |  |                                                                                                                                                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Plumber                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Plumbing                                                |  |                                                                                    |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                       |  |                                                                                                                                                          |  |                                                                                                 |  |                                                                                              |  |                                                                                    |  |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 13b. COUNTY<br>-                                                                                                                      |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                           |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |  | 13e. STREET ADDRESS<br>5906 Grace Ave. 21206                                                 |  |                                                                                    |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Leonard Yancheski Sr.                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                       |  |                                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Betty Barton                                      |  |                                                                                              |  |                                                                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>yes                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.<br>215-44-2409                                                                                                                  |  | 17. INFORMANT ADDRESS<br>Regina Yancheski (same address)                                        |  |                                                                                              |  |                                                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>9554 IMMEDIATE CAUSE (a) Gunshot wound of head<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                                                              |  |                                                                                                                                       |  |                                                                                                                                                          |  |                                                                                                 |  |                                                                                              |  |                                                                                    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                       |  |                                                                                                                                                          |  |                                                                                                 |  |                                                                                              |  |                                                                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                        |  |                                                                                                 |  | 20. AUTOPSY? (HEAD ONLY) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                                                                    |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                       |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>6PM P.M. 9-27-82                                                                                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>self/inflicted |  |                                                                                              |  |                                                                                    |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                       |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY FARM, ETC.)<br>in a pick-up truck                                                                         |  | 21f. LOCATION. STREET CITY OR TOWN COUNTY STATE<br>at 6500 Belair Rd. Baltimore, Maryland       |  |                                                                                              |  |                                                                                    |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                                                                                                                                       |  |                                                                                                                                                          |  |                                                                                                 |  |                                                                                              |  |                                                                                    |  |
| ACTUAL SIGNATURE<br>                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                       |  | TITLE (SPECIFY)<br>M.D. Assistant                                                                                                                        |  |                                                                                                 |  | DATE SIGNED<br>9-28-82                                                                       |  |                                                                                    |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Ann M. Dixon, M.D.                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                       |  | ADDRESS<br>111 Penn Street                                                                                                                               |  |                                                                                                 |  |                                                                                              |  |                                                                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br>10/1/82                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer                                                                                                      |  |                                                                                                 |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Md.                                     |  |                                                                                    |  |
| 24. FUNERAL DIRECTOR NAME<br>Schimunek Funeral Home, Inc.<br>3331 Brehms Lane, Balto. Md. 21213                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                       |  |                                                                                                                                                          |  | 25. DATE REC'D. BY REGISTRAR<br>OCT 1 - 1982                                                    |  | 25b. REGISTRAR'S SIGNATURE<br>                                                               |  |                                                                                    |  |

104

*[Handwritten signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 6 3 9

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                            |                                                                       |                                                                                                                                                  |                                                                                    |                                                                                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HAROLD YELLIN</b>                                                                                                                                                                                                                                                                            |  |                                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09/18/82</b>                |                                                                                                                                                  | 2b. HOUR<br><b>5:09p</b>                                                           |                                                                                                                               |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br><b>WHITE</b>                                                                                                                    |                                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>AUG. 5, 1916</b>                                                                                        |                                                                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b><br>YRS MONTHS DAYS<br>IF UNDER 1 YEAR<br>IF UNDER 24 HRS<br>HOURS MIN.           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                 |                                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                                             |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |                                                                       |                                                                                                                                                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>GROCCER</b> |                                                                                                                               |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>FOOD</b>                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                            |                                                                       |                                                                                                                                                  |                                                                                    |                                                                                                                               |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY<br><b>BALTO.</b>                                                                                                               |                                                                       | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                            |                                                                                    | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |
| 13e. STREET ADDRESS<br><b>3224 SHELburne RD.</b>                                                                                                                                                                                                                                                                                                            |  | 13f. # <b>21208</b>                                                                                                                        |                                                                       |                                                                                                                                                  |                                                                                    |                                                                                                                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MICHAEL YELLIN</b>                                                                                                                                                                                                                                                                                             |  |                                                                                                                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELLEN UNKNOWN</b> |                                                                                                                                                  |                                                                                    |                                                                                                                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>                                                                                                                                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.<br><b>217-05-8243</b>                                                                                             |                                                                       | 17. INFORMANT<br><b>MRS. MILDRED YELLIN</b>                                                                                                      |                                                                                    |                                                                                                                               |
| <b>WWII-ARMY</b>                                                                                                                                                                                                                                                                                                                                            |  | <b>217-05-8243</b>                                                                                                                         |                                                                       | <b>3224 SHELburne RD. BALTO., MD 21208</b>                                                                                                       |                                                                                    |                                                                                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>2089 IMMEDIATE CAUSE (a) REFRACTORY HYPERTENSION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>SEPTICEMIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ACUTE LEUKEMIA</b>                                                               |  |                                                                                                                                            |                                                                       |                                                                                                                                                  |                                                                                    | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>24 h.</b><br><b>24 h.</b><br><b>18 mos.</b>                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>ACUTE RENAL FAILURE</b>                                                                                                                                                                                          |  |                                                                                                                                            |                                                                       |                                                                                                                                                  |                                                                                    |                                                                                                                               |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                           |                                                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                        |                                                                                    | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                 |                                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                   |                                                                                    |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                     |                                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                |                                                                                    |                                                                                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/18</b> , 19 <b>82</b> , to <b>9/18</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>9/18</b> , 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death. |  |                                                                                                                                            |                                                                       |                                                                                                                                                  |                                                                                    |                                                                                                                               |
| 22b. SIGNATURE<br><b>Kevin R. Fox</b>                                                                                                                                                                                                                                                                                                                       |  | DEGREE<br><b>M.D.</b>                                                                                                                      |                                                                       | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |                                                                                    | 22c. DATE SIGNED<br><b>9/18/82</b>                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KEVIN R. FOX</b>                                                                                                                                                                                                                                                                                                |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>                                                                                              |                                                                       |                                                                                                                                                  |                                                                                    |                                                                                                                               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br><b>SEPT. 21, 1982</b>                                                                                                         |                                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH JACOB ANSHE VESHEAR</b>                                                                            |                                                                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSEDALE BALTO. MD</b>                                                       |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>                                                                                                                                                                                                                              |  |                                                                                                                                            |                                                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 23 1982</b>                                                                                              |                                                                                    | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>                                                                           |



2:00P

WASHINGTON CITY

JOHN H. HARRIS HOSPITAL

WASHINGTON

RECEIVED 10-10-1918

RECEIVED

RECEIVED

RECEIVED



RECEIVED

RECEIVED

RECEIVED 10-10-1918

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                        |  |  |  | 8 2 2 3 6 4 0<br>REG. NO.                                                                                                                                   |  |  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                      |  |  |  | 1. DECEASED NAME (TYPE OR PRINT)                                                                                                                            |  |  |  |
| FIRST MIDDLE LAST<br>VICTOR A. YOSKOSKY                                                                                                                                                                                                                                                                                                                     |  |  |  | 2. DATE OF DEATH MONTH DAY YEAR<br>9-12-82                                                                                                                  |  |  |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                              |  |  |  | 2b. HOUR<br>10:05 PM                                                                                                                                        |  |  |  |
| 4. RACE<br>Cauc                                                                                                                                                                                                                                                                                                                                             |  |  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>9 13 07                                                                                                                  |  |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.                                                                                                                                                                                                                                                                                                                  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                        |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                                                                                  |  |  |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                                                                                         |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Utilities Contractor                                                                       |  |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Johns Hopkins University Hospital                                                                                                                                                                                                                 |  |  |  | 12b. VIND OF BUSINESS OR INDUSTRY<br>Retired                                                                                                                |  |  |  |
| 13. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                       |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |  |  |  |
| 13b. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                     |  |  |  | 13e. STREET ADDRESS<br>1709 Shirley Ave.                                                                                                                    |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Arkam YOSKOSKY                                                                                                                                                                                                                                                                                                       |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Aztoula Reiler                                                                                                |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                                                                                                                                                                                                                                                         |  |  |  | 17. INFORMANT ADDRESS<br>Rozzie Stone Yoskosky - 1709 Shirley Ave.                                                                                          |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4360 Cardiac Arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) Cerebro Vascular Accident<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 minutes<br>5 days                                                                                         |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                                                                            |  |  |  |                                                                                                                                                             |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                      |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                          |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                                     |  |  |  |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                    |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                     |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                                                                                                                                              |  |  |  | 21d. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/7, 1982, to 9/12, 1982, that (I) (we) last saw the deceased alive on 9/12, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (I) did not view the body after death.                                                   |  |  |  |                                                                                                                                                             |  |  |  |
| 22b. SIGNATURE<br>John P. Knud-Hansen, MD                                                                                                                                                                                                                                                                                                                   |  |  |  | 22c. ADDRESS<br>22 S. Greene ST Baltimore, MD                                                                                                               |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial                                                                                                                                                                                                                                                                                                                   |  |  |  | 23b. DATE<br>9/15/1982                                                                                                                                      |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Spartan Cemetery                                                                                                                                                                                                                                                                                                      |  |  |  | 23d. LOCATION CITY OR TOWN<br>Perryman, Md.                                                                                                                 |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Tarrus Funeral Home                                                                                                                                                                                                                                                                                                            |  |  |  | 25. DATE REC'D. BY REGISTRAR<br>SEP 20 1982                                                                                                                 |  |  |  |
| 25a. REGISTRAR'S SIGNATURE<br>John J. Carver                                                                                                                                                                                                                                                                                                                |  |  |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                                  |  |  |  |

CHIEF OF BUREAU



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 20 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

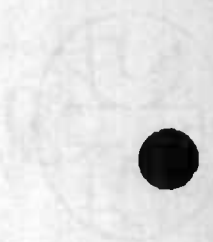
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 6 4 1  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                        |                                                                                                                                                          |                                                                  |                                                                                                 |                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Beatrice Young</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                        |                                                                                                                                                          | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9/8/82</b>             |                                                                                                 | 2b. HOUR<br><b>8:16 PM</b>        |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 4. RACE<br><b>Black</b>                                                                                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 17 65</b>                                                                                                     |                                                                  | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.                                            |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. Carolina</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                             | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b> |                                                                                                                                                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                        | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                          | 13c. CITY OR TOWN<br><b>Baltimore</b>                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel Hillian</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nellie Robinson</b>                                                                                  |                                                                  |                                                                                                 |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                        | 16b. SOCIAL SECURITY NO.<br><b>212-34-7126</b>                                                                                                           |                                                                  | 17. INFORMANT<br>ADDRESS<br><b>Bernice Johnson 2911 Walbrook Ave</b>                            |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>(IMMEDIATE CAUSE (b)) <b>Cardiopulmonary arrest 2<sup>o</sup></b><br>5140<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(a) <b>chronic emphysema</b><br>35 days<br>(c) <b>acute pulmonary edema &amp; respiratory failure</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d):<br><b>Hypertensive &amp; arteriosclerotic heart disease</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>mins</b> |                                                                                                                                        |                                                                                                                                                          |                                                                  |                                                                                                 |                                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                                  | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                        | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                               |                                                                  | 20c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 21, PART 1 OR PART 2)                 |                                   |
| 21a. INJURY OCCURRED:<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                        | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                   |                                                                  | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                   |
| 22. I certify that (1) this hospital attended the deceased from <b>9/8</b> 19 <b>82</b> to <b>9/8</b> 19 <b>82</b> and that (2) my (our) opinion death occurred on the date and hour and from the causes stated above. (If two (did) did not view the body after death.                                                                                                                                                                                                                                                                                                                               |                                                                                                                                        |                                                                                                                                                          |                                                                  |                                                                                                 |                                   |
| 22a. SIGNATURE<br><b>Eltan Saunders</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                        | DEGREE                                                                                                                                                   |                                                                  | 22c. DATE SIGNED                                                                                |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ELTAN SAUNDERS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                        | 22e. ADDRESS<br><b>Provident Hospital</b>                                                                                                                |                                                                  |                                                                                                 |                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                        | 23b. DATE<br><b>9/14/82</b>                                                                                                                              |                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill cem</b>                                     |                                   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C. March F/H</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                        | ADDRESS<br><b>1101 E. North Ave</b>                                                                                                                      |                                                                  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 10 1982</b>                                             |                                   |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                        |                                                                                                                                                          |                                                                  |                                                                                                 |                                   |



SEP 1 1932

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 2 2 3 6 4 2  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                           |  |                                                                                                                                                                                                                                               |  |                                                                     |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                        |  | 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                       |  | 2a. DATE OF DEATH                                                                                                                                                                                                                             |  | 2b. HOUR                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                     |  | Dennis Young                                                                                              |  | 9/16/82                                                                                                                                                                                                                                       |  | M                                                                   |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE                                                                                                   |  | 5. DATE OF BIRTH                                                                                                                                                                                                                              |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| Male                                                                                                                                                                                                                                                                                                                                                                |  | Black                                                                                                     |  | 5/30/1920                                                                                                                                                                                                                                     |  | 62                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| N.C.                                                                                                                                                                                                                                                                                                                                                                |  | U.S.A.                                                                                                    |  |                                                                                                                                                                                                                                               |  | Baltimore, Maryland MD.                                             |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                                                                                                              |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                           |  | Union Mem. Hospital                                                                                       |  | Longshorem an                                                                                                                                                                                                                                 |  | -----                                                               |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                          |  | 13b. COUNTY                                                                                               |  | 13c. CITY OR TOWN                                                                                                                                                                                                                             |  | 13d. INSIDE CITY LIMITS?                                            |  |
| Md.                                                                                                                                                                                                                                                                                                                                                                 |  | ---                                                                                                       |  | Baltimore                                                                                                                                                                                                                                     |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                              |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                             |  | 13e. STREET ADDRESS                                                                                                                                                                                                                           |  |                                                                     |  |
| Hartford Young                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                           |  | 3307 Mondawmin Ave. 21216                                                                                                                                                                                                                     |  |                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.                                                                                  |  | 17. INFORMANT                                                                                                                                                                                                                                 |  | ADDRESS                                                             |  |
| -----0-----                                                                                                                                                                                                                                                                                                                                                         |  | 243-16-5226                                                                                               |  | Flossie Young, 3307 Mondawmin Ave.                                                                                                                                                                                                            |  | 21216                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>4100</i> <i>Probable acute myocardial infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>ASKE 7 previous M.I.</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>10 yrs</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                           |  |                                                                                                                                                                                                                                               |  |                                                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                  |  |                                                                                                           |  |                                                                                                                                                                                                                                               |  |                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  | 20a. AUTOPSY?                                                                                                                                                                                                                                 |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                           |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                      |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                            |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                                                                                                |  |                                                                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                             |  |                                                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/5</i> , 19 <i>73</i> , to <i>9/16</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>4/30</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |                                                                                                           |  |                                                                                                                                                                                                                                               |  |                                                                     |  |
| 22b. SIGNATURE<br><i>Elijah Saunders</i>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                           |  | DEGREE<br>ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/><br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>9/21/82                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Elijah Saunders, M. D.                                                                                                                                                                                                                                                                                                     |  |                                                                                                           |  | 22e. ADDRESS<br>2 Hamill Road Balto., Md. 21210                                                                                                                                                                                               |  |                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                        |  | 23b. DATE                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                                                                                                            |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |
| Burial                                                                                                                                                                                                                                                                                                                                                              |  | 9/20/82                                                                                                   |  | Maryland Nat Pk                                                                                                                                                                                                                               |  | Laurel Maryland                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                           |  | 24b. ADDRESS                                                                                                                                                                                                                                  |  | 24c. DATE REC'D. BY REGISTRAR (REGISTERAR'S SIGNATURE)              |  |
| Law Funeral Home 4611 Park Heights Ave.                                                                                                                                                                                                                                                                                                                             |  |                                                                                                           |  |                                                                                                                                                                                                                                               |  | SEP 22 1982                                                         |  |



UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

| No. |  | Date |       | Locality   |  | Collector |  | Remarks |  |
|-----|--|------|-------|------------|--|-----------|--|---------|--|
| 1   |  | 1911 | 10/10 | California |  |           |  |         |  |
| 2   |  | 1911 | 10/10 | California |  |           |  |         |  |
| 3   |  | 1911 | 10/10 | California |  |           |  |         |  |
| 4   |  | 1911 | 10/10 | California |  |           |  |         |  |
| 5   |  | 1911 | 10/10 | California |  |           |  |         |  |
| 6   |  | 1911 | 10/10 | California |  |           |  |         |  |
| 7   |  | 1911 | 10/10 | California |  |           |  |         |  |
| 8   |  | 1911 | 10/10 | California |  |           |  |         |  |
| 9   |  | 1911 | 10/10 | California |  |           |  |         |  |
| 10  |  | 1911 | 10/10 | California |  |           |  |         |  |

1911-1912  
California  
A. J. ...  
...

1911-1912  
California  
A. J. ...  
...

1911-1912  
California  
A. J. ...  
...



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                       |  |                                                                                                                                  |                                                                       |                                                                                                                                                             |                                                                                 |                                                                                      |                                                                  |                                                                                                                            |                                                                                                 | REG. NO. 8 2 2 3 6 4 3 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>MARY E ZAHALKA                                                                                                                                                                                                                                                    |  |                                                                                                                                  |                                                                       |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br>9 24 82                                     |                                                                                      |                                                                  | 2b. HOUR<br>6:50 AM                                                                                                        |                                                                                                 |                        |  |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br>White                                                                                                                 |                                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 8 24                                                                                                                |                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58 YRS                                            |                                                                  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |                                                                                                 |                        |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                           |                                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |                                                                  |                                                                                                                            |                                                                                                 |                        |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan Hosp |                                                                       |                                                                                                                                                             |                                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Secretary        |                                                                  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Insurance Co.                                                                         |                                                                                                 |                        |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                  |                                                                       |                                                                                                                                                             | 13b. COUNTY                                                                     |                                                                                      | 13c. CITY OR TOWN<br>Baltimore                                   |                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Richard A. Dawson                                                                                                                                                                                                                                                                |  |                                                                                                                                  |                                                                       |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Laura May Greene               |                                                                                      |                                                                  |                                                                                                                            |                                                                                                 |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                                                                                                                                                                                                       |  |                                                                                                                                  |                                                                       |                                                                                                                                                             | 16b. SOCIAL SECURITY NO.<br>219-16-2702                                         |                                                                                      | 17. INFORMANT ADDRESS<br>Martha E. Watson 2510 Hamilton Ave.     |                                                                                                                            |                                                                                                 |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) PULMONARY ARREST<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CA of LUNG<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                      |  |                                                                                                                                  |                                                                       |                                                                                                                                                             |                                                                                 |                                                                                      |                                                                  |                                                                                                                            |                                                                                                 |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10                                                                                                                                                                                        |  |                                                                                                                                  |                                                                       |                                                                                                                                                             |                                                                                 |                                                                                      |                                                                  |                                                                                                                            |                                                                                                 |                        |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |                                                                                                                                                             |                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                   |  |                                                                                                                                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19            |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) |                                                                                      |                                                                  |                                                                                                                            |                                                                                                 |                        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                  |  |                                                                                                                                  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                               |                                                                                      |                                                                  |                                                                                                                            |                                                                                                 |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from May 25, 19 82, to Sept 24, 19 82, that (I) (we) lost saw the deceased alive on Sept 24, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                  |                                                                       |                                                                                                                                                             |                                                                                 |                                                                                      |                                                                  |                                                                                                                            |                                                                                                 |                        |  |
| 22b. SIGNATURE<br>P. Kennedy M.D.                                                                                                                                                                                                                                                                                          |  |                                                                                                                                  |                                                                       |                                                                                                                                                             | DEGREE                                                                          |                                                                                      |                                                                  | 22c. DATE SIGNED<br>9/24/82                                                                                                |                                                                                                 |                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PETER KENNEDY, M.D.                                                                                                                                                                                                                                                               |  |                                                                                                                                  |                                                                       |                                                                                                                                                             | 22e. ADDRESS<br>Good Samaritan Hosp                                             |                                                                                      |                                                                  |                                                                                                                            |                                                                                                 |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                     |  |                                                                                                                                  | 23b. DATE<br>Sept. 27, 1982                                           |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park                               |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |                                                                                                                            |                                                                                                 |                        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc. Baltimore, Maryland                                                                                                                                                                                                                                                  |  |                                                                                                                                  |                                                                       |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>SEP 27 1982                                    |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br>John J. [Signature]                |                                                                                                                            |                                                                                                 |                        |  |

U.S. DEPARTMENT OF THE ARMY  
WASHINGTON, D.C.

U.S. DEPARTMENT OF THE ARMY  
WASHINGTON, D.C.  
OFFICE OF THE SECRETARY  
ATTENTION: Mr. [Name]  
1015 [Address]  
[City], [State]

U.S. DEPARTMENT OF THE ARMY  
WASHINGTON, D.C.  
OFFICE OF THE SECRETARY  
ATTENTION: Mr. [Name]  
1015 [Address]  
[City], [State]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained in 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

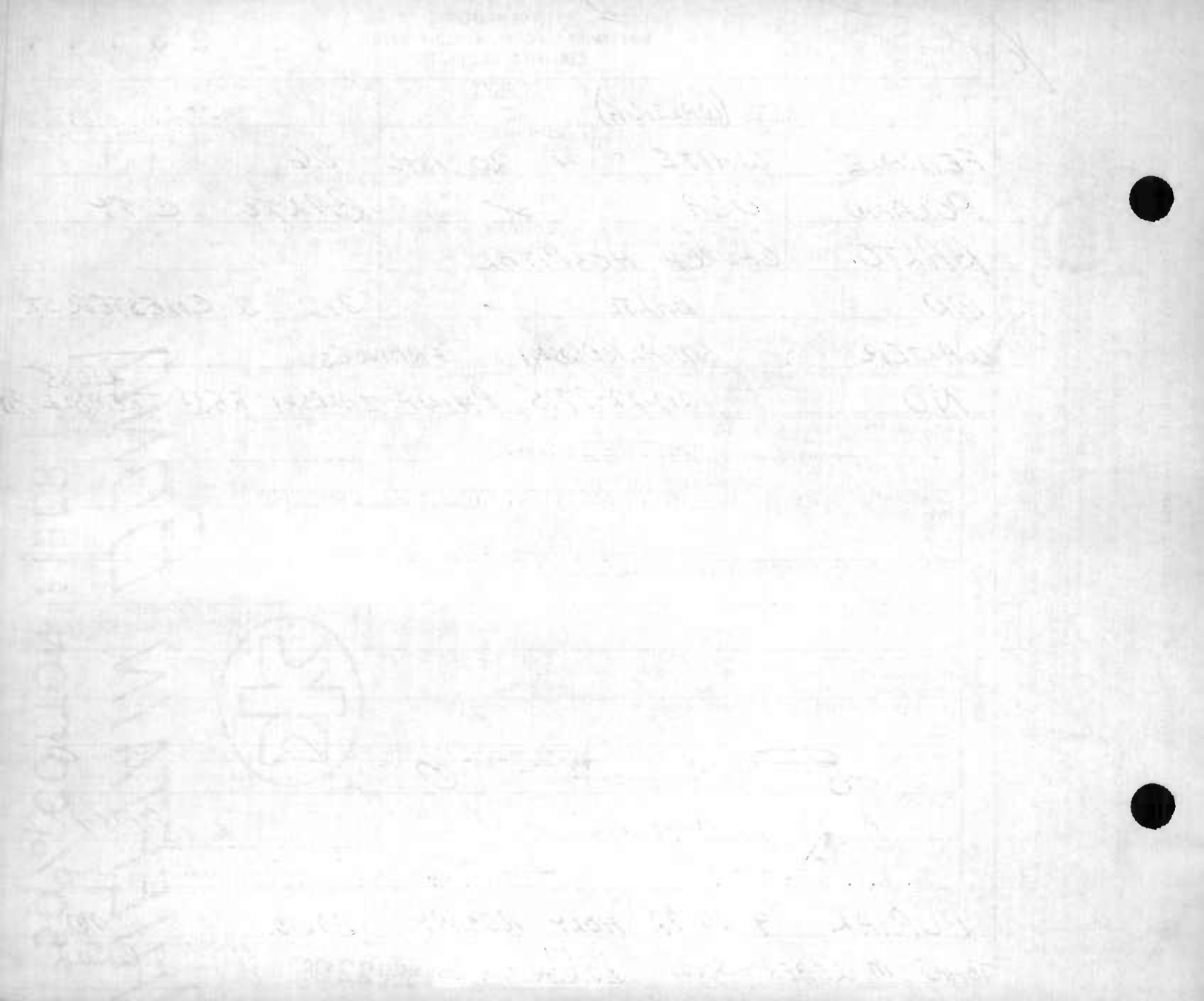
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 5 4 4

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                                            |                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                         |  | FIRST MIDDLE LAST<br>MOLLIE (WALERIA) ZALESKI<br>AK                                                                          |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>09-16-82                                                                                                                |  | 2b. HOUR<br>8:56pm                                                                                                         |                                              |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br>WHITE                                                                                                             |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>4 20 1896                                                                                                                |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.<br>86                                                          |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>POLAND                                                                                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                          |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY MD.                                                                    |                                              |
| 10. CITY OR TOWN OF DEATH<br>BALTO.                                                                                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>CHURCH HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                              |
| 13a. STATE<br>MD.                                                                                                                                                                                                                                                                                                                                                                                                           |  | 13b. COUNTY                                                                                                                  |  | 13c. CITY OR TOWN<br>BALTO                                                                                                                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>WALTER SMALKOWSKI                                                                                                                                                                                                                                                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>FRANCES                                                                        |  | 13e. STREET ADDRESS<br>312 S. CHESTER ST.                                                                                                                   |  |                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NOT OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                                                                 |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-22-7775                                                       |  | 17. INFORMANT ADDRESS<br>PHILIP ZALESKI R533 TREMBLE RD 21085                                                                                               |  |                                                                                                                            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u><br>4100<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>ACUTE MYOCARDIAL INFARCTION</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ACUTE MYOCARDIAL INFARCTION</u><br>DUE TO, OR AS A CONSEQUENCE OF |  |                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                         |  |                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.)                                                            |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>XXXXX 9-11-19-82</u> to <u>9-16-19-82</u> that (I/we) lost <u>9-16-19-82</u> above, (I/we did) (did not) view the body after death.                                                                                                                                                                                                                   |  |                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                                            |                                              |
| 22b. SIGNATURE<br>A.F. Nazemi MD.                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                              |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>9/16/82                                                                                                |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. A.F. NAZEMI MD.D                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                              |  | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION<br>100 N. BROADWAY BALTIMORE MARYLAND 21231                                                                     |  |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br>9-20-82                                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br>HOLY ROSARY                                                                                                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD.                                                                   |                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br>JOHN M. WEBER & SONS                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                              |  | 25a. DATE REC'D. BY REGISTRAR<br>401<br>S. CHESTER                                                                                                          |  | 25b. REGISTRAR'S SIGNATURE<br>SEP 22 1982                                                                                  |                                              |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 6 4 5  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                    |                                                       |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Sr. Martiana Zebron</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                    | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9-14-82</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>8:12 PM</b>                                                                                                                 |  |                                                                                                                            |  |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br><b>W</b>                                                                                                                |                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12-31-27</b>                                                                                                       |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b>                                                                                               |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                        |  |
| 7b. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                |  | 7c. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                         |                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. city</b> MD.                                                                             |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto</b>                                                                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital</b> |                                                       |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RELIGIOUS</b>                                                       |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                        |  | 13b. COUNTY<br><b>Balto</b>                                                                                                        |                                                       | 13c. CITY OR TOWN<br><b>Balto</b>                                                                                                                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                            |  | 13e. STREET ADDRESS<br><b>517 S. Luzerne Ave</b>                                                                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Zebron</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                    |                                                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Jennie Popera</b>                                                                                       |  |                                                                                                                                            |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO.<br><b>579-68-1018</b>                                                                                     |                                                       | 17. INFORMANT<br><b>Jennie Zebron</b>                                                                                                                       |  | ADDRESS<br><b>517 S. Luzerne Ave</b>                                                                                                       |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiovascular collapse</b><br><b>2000</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Diffuse histiocytic lymphoma c</b><br><b>metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (lost). |  |                                                                                                                                    |                                                       |                                                                                                                                                             |  |                                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                                                                             |  |                                                                                                                                    |                                                       |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |                                                       |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                  |                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                                                                            |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                             |                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                                            |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/10</b> , 19 <b>82</b> , to <b>9/14</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>9/14</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                             |  |                                                                                                                                    |                                                       |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>A. Reisinger MD</b>                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                    |                                                       | DEGREE                                                                                                                                                      |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>9/14/82</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. Reisinger</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                    |                                                       | 22e. ADDRESS<br><b>Mercy Hospital</b>                                                                                                                       |  |                                                                                                                                            |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br><b>9-18-82</b>                                                                                                        |                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Stanislaus</b>                                                                                                 |  | 23d. LOCATION<br><b>Baltimore City, Md.</b>                                                                                                |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>(NAME)<br><b>Raymond S. Kuzanski</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                    |                                                       | ADDRESS<br><b>2525 North St.</b>                                                                                                                            |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 17 1982</b>                                                                                        |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                                                        |  |

MEDICAL CERTIFICATION

2  
935  
37  
38  
300  
1

0103 BP



*[Faint, mostly illegible handwriting covering the upper half of the page. Some words like 'The', 'and', 'of' are visible.]*

*[Faint handwriting in the lower half of the page, appearing to be a list or series of notes.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 6 4 6  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                     |                                                                                                 |                                                     |                                                                                                                            |                                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ALBERT THOMAS ZELLERS SR.</b>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>SEPTEMBER 10, 1982</b>       |                                                                                                                                                             |                                                     | 2b. HOUR<br><b>5:32 PM</b>                                                                      |                                                     |                                                                                                                            |                                                                                                                                            |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE<br><b>WHITE</b>                                                                                                                     |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JANUARY 24 1920</b>                                                                                                |                                                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b>                                                    |                                                     | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>                                                                |                                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                               |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                               |                                                     |                                                                                                                            |                                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GOOD SAMARITAN HOSPITAL</b> |                                                                        |                                                                                                                                                             |                                                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SR. DESIGNER</b>         |                                                     | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BETH STEEL</b>                                                                     |                                                                                                                                            |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                              |  | 13b. COUNTY<br><b>---</b>                                                                                                                   |                                                                        | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                       |                                                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                     | 13e. STREET ADDRESS<br><b>407 ELRINO ST. 21224</b>                                                                         |                                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ADAM ZELLERS</b>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                             |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>HELEN C ZUCHOWSKI</b>                                                                                   |                                                     |                                                                                                 |                                                     | 16. ADDRESS<br><b>407 ELRINO ST. BALTO. MD. 21224</b>                                                                      |                                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No ---</b>                                                                                                                                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.<br><b>214-05-3816</b>                                                                                              |                                                                        | 17. INFORMANT<br><b>MARIE C. ZELLERS</b>                                                                                                                    |                                                     | 18. ADDRESS<br><b>BALTO. MD. 21224</b>                                                          |                                                     |                                                                                                                            |                                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Small cell lung carcinoma-metastatic</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>~1 yr.</b> |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                     |                                                                                                 |                                                     |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                                         |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                     |                                                                                                 |                                                     |                                                                                                                            |                                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                   |  |                                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |                                                                                                                                                             |                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |                                                     |                                                                                                                            |                                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                  |  |                                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                     |                                                                                                                            |                                                                                                                                            |
| 22a. I certify that (H) (this hospital) attended the deceased from <b>AUGUST 13</b> , 19 <b>82</b> , to <b>SEPTEMBER 10</b> , 19 <b>82</b> , that (H) (we) last saw the deceased alive on <b>SEPTEMBER 10</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.    |  |                                                                                                                                             |                                                                        |                                                                                                                                                             |                                                     |                                                                                                 |                                                     |                                                                                                                            |                                                                                                                                            |
| 22b. SIGNATURE<br><b>Paul Chang, MD</b>                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                             |                                                                        |                                                                                                                                                             | DEGREE<br><b>MD</b>                                 |                                                                                                 | 22c. DATE SIGNED<br><b>SEPTEMBER 10, 1982</b>       |                                                                                                                            | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Paul Chang, MD</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                             |                                                                        |                                                                                                                                                             | 22e. ADDRESS<br><b>Good Samaritan Hospital</b>      |                                                                                                 |                                                     |                                                                                                                            |                                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE<br><b>9-14-82</b>                                                                                                                 |                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SACRED HEART</b>                                                                                                   |                                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>DUNDALK, BALTO. CO., MD.</b>                   |                                                     |                                                                                                                            |                                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>C.S. ZEILERT+SON INC. 6224 EASTERN AV.</b>                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                             |                                                                        |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 14 1982</b> |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canine</b> |                                                                                                                            |                                                                                                                                            |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHM-16 50M 1/B1  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                     |  |                                                                                                                            |                                                               |                                                                                                                                                             |                                            |                                                                                                                                            |                                                                                          |                                                                                                                               |                                                           |                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|---------------------|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                             |  | REG. NO. 8 2 2 3 6 4 7                                                                                                     |                                                               |                                                                                                                                                             |                                            |                                                                                                                                            |                                                                                          |                                                                                                                               |                                                           |                     |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>ZORA L. ZIMMERMAN                                                                                                                                                                                                                               |  |                                                                                                                            |                                                               |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br>9 6 82 |                                                                                                                                            |                                                                                          |                                                                                                                               |                                                           | 2b. HOUR<br>1159 PM |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                         |  | 4. RACE<br>White                                                                                                           |                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 06 '09                                                                                                             |                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.                                                                                                 |                                                                                          | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |                                                           |                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Indiana                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                        |                                                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County City MD.                                                                          |                                                                                          |                                                                                                                               |                                                           |                     |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>City Hospital |                                                               |                                                                                                                                                             |                                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerical                                                               |                                                                                          | 12b. KIND OF BUSINESS OR INDUSTRY<br>Civil Serv. Adm.                                                                         |                                                           |                     |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                   |  |                                                                                                                            |                                                               |                                                                                                                                                             | 13b. COUNTY<br>Baltimore                   |                                                                                                                                            | 13c. CITY OR TOWN<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                               | 13d. STREET ADDRESS                                       |                     |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Nicholas ? Zimmerman                                                                                                                                                                                                                                           |  |                                                                                                                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mabel ? Hass |                                                                                                                                                             |                                            |                                                                                                                                            |                                                                                          |                                                                                                                               |                                                           |                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                                                                                                                                                                                   |  | 16b. SOCIAL SECURITY NO.<br>411-05-8237                                                                                    |                                                               | 17. INFORMANT<br>Miss. Philomena Demasi                                                                                                                     |                                            | ADDRESS<br>6713 Gary Avenue<br>Baltimore, Md. 21222                                                                                        |                                                                                          |                                                                                                                               |                                                           |                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Congestive Heart Failure<br>4280<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                           |  |                                                                                                                            |                                                               |                                                                                                                                                             |                                            |                                                                                                                                            |                                                                                          |                                                                                                                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>MONTHS |                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                       |  |                                                                                                                            |                                                               |                                                                                                                                                             |                                            |                                                                                                                                            |                                                                                          |                                                                                                                               |                                                           |                     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                           |                                                               |                                                                                                                                                             |                                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |                                                                                          | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                           |                     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                 |                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                                                                              |                                            |                                                                                                                                            |                                                                                          |                                                                                                                               |                                                           |                     |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                           |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM, ETC.)                                                         |                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                            |                                                                                                                                            |                                                                                          |                                                                                                                               |                                                           |                     |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/6 1982 to 9/6 1982, that (I) (we) last saw the deceased alive on 9/6 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                            |                                                               |                                                                                                                                                             |                                            |                                                                                                                                            |                                                                                          |                                                                                                                               |                                                           |                     |
| 22b. SIGNATURE<br>Richard A. Joseph                                                                                                                                                                                                                                                                      |  |                                                                                                                            |                                                               | DEGREE<br>MSMD                                                                                                                                              |                                            | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                          | 22c. DATE SIGNED<br>9/7/82                                                                                                    |                                                           |                     |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Richard A. Joseph                                                                                                                                                                                                                                               |  |                                                                                                                            |                                                               | 22e. ADDRESS<br>Baltimore City Hosp                                                                                                                         |                                            |                                                                                                                                            |                                                                                          |                                                                                                                               |                                                           |                     |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                   |  | 23b. DATE<br>09/10/82                                                                                                      |                                                               | 23c. NAME OF CEMETERY OR CREMATORY<br>Sacred Heart Of Jesus                                                                                                 |                                            | 23d. LOCATION<br>XXXXXX                                                                                                                    |                                                                                          | COUNTY STATE<br>Baltimore Md.                                                                                                 |                                                           |                     |
| 24. FUNERAL DIRECTOR<br>NAME<br>Walter Dabrowski                                                                                                                                                                                                                                                         |  |                                                                                                                            |                                                               | ADDRESS<br>1005 Dundalk Avenue 21224                                                                                                                        |                                            | 25a. DATE REC'D. BY REGISTRAR<br>SEP 14 1982                                                                                               |                                                                                          |                                                                                                                               |                                                           |                     |
| REGISTRAR'S SIGNATURE<br>Joan J. Conner                                                                                                                                                                                                                                                                  |  |                                                                                                                            |                                                               |                                                                                                                                                             |                                            |                                                                                                                                            |                                                                                          |                                                                                                                               |                                                           |                     |

|           |               |    |    |     |                       |
|-----------|---------------|----|----|-----|-----------------------|
| Female    | White         | 12 | 05 | '09 | VI                    |
| Indiana   | USA           |    |    |     | Baltimore County      |
| Baltimore | City Hospital |    |    |     | Clerical              |
| Maryland  | Baltimore     |    |    |     |                       |
| Nicholas  | Kimberlin     |    |    |     | Mabel                 |
| No        | 411-05-5237   |    |    |     | Miss. Richmond Dennis |
|           |               |    |    |     | 0713 Gary Avenue      |
|           |               |    |    |     | Baltimore, Md. 21222  |

09/10/82      Sacred Heart of Jesus      Baltimore      No. 1005 Dundalk Avenue 21224      Alfred Dabrowski      Burial

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                   |  | 8 2 2 3 6 4 8<br>REG. NO.                                                                                                                                   |  |                                                                                                                         |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME (FIRST, MIDDLE, LAST)<br><b>PAULINE ZNAMIROWSKI</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>SEPTEMBER 7, 1982</b>                                                                                                |  | 2b. HOUR MIN.<br><b>10:45 AM</b>                                                                                        |                                              |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br><b>Caucasian</b>                                                                                                       |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Aug 18, 1899</b>                                                                                                      |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>85</b> YRS.                                                                     |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                        |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                                       |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hosp Inc.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Domestic Help</b>                                                                       |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |                                              |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>114</b>                                                                                                                                                                                                                                                                                                                 |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                             |                                              |
| 14. FATHER'S NAME (FIRST, MIDDLE, LAST)<br><b>John Dilla</b>                                                                                                                                                                                                                                                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME (FIRST, MIDDLE, LAST)<br><b>Unknown</b>                                                                  |  | 16. STREET ADDRESS<br><b>523 S. Lenwood</b>                                                                                                                 |  |                                                                                                                         |                                              |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                 |  | 17b. SOCIAL SECURITY NO.<br><b>1</b>                                                                                              |  | 17. INFORMANT ADDRESS<br><b>Pltn Znamirovski 7705 Waverline Ave</b>                                                                                         |  |                                                                                                                         |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>PNEUMONIA, URINARY TRACT INFECTION</b>                                                                                                                                                                                                                                           |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                                         |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                         |                                              |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)                                                                 |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                         |                                              |
| 22a. I certify that (1) this hospital attended the deceased from <b>AUGUST 26</b> 19 <b>82</b> , to <b>SEPTEMBER 7</b> 19 <b>82</b> , that (1) <b>we</b> last saw the deceased alive on <b>SEPTEMBER 7</b> 19 <b>82</b> , and that in (my) <b>our</b> opinion death occurred on the date and hour and from the causes stated above, (1) <b>we</b> did not view the body after death.                                       |  |                                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                                         |                                              |
| 22b. SIGNATURE<br><b>A. P. Nazemi M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>9/7/82</b>                                                                                       |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ATAOLLAH F. NAZEMI, M.D.</b>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                   |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 N. BROADWAY, BALTIMORE, MD 21231</b>                                                                 |  |                                                                                                                         |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                 |  | 23b. DATE<br><b>9-11-82</b>                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Stanislaus</b>                                                                                                 |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore City MD</b>                                                     |                                              |
| 24. FUNERAL DIRECTOR NAME<br><b>Raymond Znamirovski</b>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                   |  | ADDRESS<br><b>5525 North St.</b>                                                                                                                            |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 17 1982</b>                                                                     |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                                                                                                         |  |                                                                                                                         |                                              |



Handwritten text on lined paper, mostly illegible due to fading. The text appears to be organized into columns and rows, possibly a ledger or record book. Some legible fragments include:

- Top left: "11/11/11"
- Top center: "11/11/11"
- Top right: "11/11/11"
- Middle left: "11/11/11"
- Middle center: "11/11/11"
- Middle right: "11/11/11"
- Bottom left: "11/11/11"
- Bottom center: "11/11/11"
- Bottom right: "11/11/11"

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DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 6 4 9

REG. NO.

|                                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                  |  |                                              |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|----------------------------------|--|----------------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                       |  | 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                    |  | FIRST MIDDLE LAST                                                                                                                                        |  | 2a. DATE OF DEATH                                                   |  | MONTH DAY YEAR                   |  | 2b. HOUR                                     |  |
|                                                                                                                                                                                                                                                                                                                    |  | JESSIE Marie JONES ZOSH                                                                                |  |                                                                                                                                                          |  | 09/06/82                                                            |  |                                  |  | 6:40P <sup>M</sup>                           |  |
| 3. SEX                                                                                                                                                                                                                                                                                                             |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                  |  | 7. MONTHS DAYS HOURS MIN.                    |  |
| Female                                                                                                                                                                                                                                                                                                             |  | White                                                                                                  |  | 11 19 1938                                                                                                                                               |  | 13 YRS                                                              |  |                                  |  |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                  |  |                                              |  |
| Louisiana                                                                                                                                                                                                                                                                                                          |  | USA                                                                                                    |  |                                                                                                                                                          |  | Baltimore City                                                      |  |                                  |  | MD.                                          |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                  |  |                                              |  |
| Baltimore                                                                                                                                                                                                                                                                                                          |  | The Johns Hopkins Hospital                                                                             |  | Homemaker                                                                                                                                                |  | Home                                                                |  |                                  |  |                                              |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS              |  |                                              |  |
| Maryland                                                                                                                                                                                                                                                                                                           |  | Harford                                                                                                |  | Edgewood                                                                                                                                                 |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 619 Lacewood Avenue              |  |                                              |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME                                                                               |  | 16. SOCIAL SECURITY NO.                                                                                                                                  |  | 17. INFORMANT                                                       |  | ADDRESS                          |  |                                              |  |
| Jesse                                                                                                                                                                                                                                                                                                              |  | Orie                                                                                                   |  | 125-90-6611                                                                                                                                              |  | Joseph J. Zosh                                                      |  | 619 Lacewood Ave., Edgewood, Md. |  | 21040                                        |  |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                  |  | 18b. SOCIAL SECURITY NO.                                                                               |  | 19. INFORMANT                                                                                                                                            |  | ADDRESS                                                             |  |                                  |  |                                              |  |
| No                                                                                                                                                                                                                                                                                                                 |  | 125-90-6611                                                                                            |  | Joseph J. Zosh                                                                                                                                           |  | 619 Lacewood Ave., Edgewood, Md.                                    |  |                                  |  |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                              |  | IMMEDIATE CAUSE (a)                                                                                    |  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                                           |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  | DUE TO, OR AS A CONSEQUENCE OF   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 1830                                                                                                                                                                                                                                                                                                               |  | CARDIO PULMONARY ARREST                                                                                |  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                                           |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  | DUE TO, OR AS A CONSEQUENCE OF   |  | 1980                                         |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                  |  |                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                                   |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                  |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY?                                                                                                                                            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                                  |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                      |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                                  |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                 |  | 21b. TIME OF INJURY                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                     |  |                                  |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                    |  | HOUR A.M. MONTH DAY YEAR                                                                               |  |                                                                                                                                                          |  |                                                                     |  |                                  |  |                                              |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)                                        |  | 21f. LOCATION                                                                                                                                            |  |                                                                     |  |                                  |  |                                              |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                  |  |                                                                                                        |  | STREET                                                                                                                                                   |  | CITY OR TOWN                                                        |  | COUNTY                           |  | STATE                                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2 SEPT 19 82 to 6 SEPT 19 82, that (I) (we) last saw the deceased alive on 6 SEPT 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (Type: (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                  |  |                                              |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                     |  | DEGREE                                                                                                 |  | 22c. DATE SIGNED                                                                                                                                         |  |                                                                     |  |                                  |  |                                              |  |
| Stanford L. Walker MD                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  | 9/6/82                                                                                                                                                   |  |                                                                     |  |                                  |  |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                              |  | 22e. ADDRESS                                                                                           |  |                                                                                                                                                          |  |                                                                     |  |                                  |  |                                              |  |
| Stanford L. Walker MD                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |                                  |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                          |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION                                                       |  |                                  |  |                                              |  |
| Burial                                                                                                                                                                                                                                                                                                             |  | 9 Sep. 1982                                                                                            |  | Angel Hill Cemetery                                                                                                                                      |  | Hayre de Grace Harford Md.                                          |  |                                  |  |                                              |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                               |  | 25a. DATE REC'D. BY REGISTRAR                                                                          |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                               |  |                                                                     |  |                                  |  |                                              |  |
| Tarring Funeral Home, P.A., Aberdeen, Md. 21001-3199                                                                                                                                                                                                                                                               |  | SEP 14 1982                                                                                            |  | John J. Smith                                                                                                                                            |  |                                                                     |  |                                  |  |                                              |  |

MEDICAL CERTIFICATION

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